DOCUMENT RESUME

ED 064 490 VT 015 708

AUTHOR Anderson, Miles H.
TITLE The Clinical Instructor Training Program: Development, Operation, Evaluation. Final Report.
INSTITUTION California Univ., Los Angeles. Div. of Vocational Education.
SPONS AGENCY Social and Rehabilitation Service (DHEW), Washington, D.C. Div. of Research and Demonstration Grants.
PUB DATE Sep 71
NOTE 95p.
AVAILABLE FROM The Regents, Univ. of Calif., LA, Div. of Vocational Education, Allied Health Professions Project, 1003 Wilshire Blvd., Santa Monica, Calif. 90401 (Make checks payable to: The Regents, University of California, $2.00)

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS Demonstration Projects; *Health Occupations Education; Health Personnel; *On the Job Training; *Paramedical Occupations; Program Development; Program Evaluation; *Supervisory Training; *Teaching Techniques

ABSTRACT

To determine if on the job training of allied health personnel could be improved by offering supervisors a short seminar in teaching techniques, a 12-hour program was developed, and 1,299 participants were trained over a 3-year period. The five training sessions utilized demonstration and "learning by doing" techniques to teach participants how to organize inservice training and teach on the job. To evaluate the effectiveness of the program, questionnaires were mailed to participants. Over 80 percent of the 429 respondents felt the program was outstanding or well done, and an equal number indicated that as a result of the program, patient care had been improved to some extent. The results indicate that the training should be continued and expanded, and that similar short seminars in other aspects of human relations, supervision, leadership, and management should be prepared and offered in the health care field. Instruction cards, a job break-down sheet, certificates, a copy of the survey instrument, and other study materials are appended. (Author/SB)

ED 064490

FINAL REPORT

THE CLINICAL INSTRUCTOR TRAINING PROGRAM:

DEVELOPMENT, OPERATION, EVALUATION

MILES H. ANDERSON, ED.D.
DIRECTOR

This investigation was supported, in part,
by Demonstration Grant No. 44-P-45063/9-03,
Division of Research and Demonstration
Grants, Social and Rehabilitation Service,
Department of Health, Education, and Welfare.

UNIVERSITY OF CALIFORNIA
Division of Vocational Education
Los Angeles, California

VT015708

SEPTEMBER 1971

Final Report

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UNIVERSITY OF CALIFORNIA
Division of Vocational Education
Los Angeles, California

September 1971

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FOREWORD

The Division of Vocational Education, an administrative unit of the statewide University of California, is concerned primarily with teacher education, research, and service in the broad area of adult, vocational, and technical education.

The Division sponsored the Clinical Instructor Training program to investigate the feasibility of improving the skills and knowledge of health care workers through organized programs of on-the-job training in hospitals and other health care institutions. Because the supervisor is the key person in successful on-the-job training programs, the Clinical Instructor Training program proposed to train health care supervisors in how to organize an efficient in-service training program, how to prepare to teach, and how to teach effectively, in the on-the-job environment. This final report is a statement of the results of a three-year trial period in which the Clinical Instructor Training program was organized, operated, and evaluated.

From the inception of programs of vocational education in the United States, advisory committees have played an important role. They provide the bridge between the educational institutions and the employer organizations, and thus make the transition from the one to the other more practical and realistic. In the case of the Clinical Instructor Training program, it being one of the projects in the Allied Health Professions Projects, the National Advisory Committee for the latter served as the advisory committee for the former. The Clinical Instructor Training program was submitted for scrutiny at each meeting of the committee, and the members' advice on its organization and operation was helpful. The members of the committee are:

Phillip L. Williams, Chairman
Vice President, The Times Mirror Company
Los Angeles, California

Lowell Burkett, Executive Director
American Vocational Association
Washington, D.C.

L. M. Detmer, Director
Bureau of Health Manpower and Education
American Hospital Association, Chicago, Illinois

Dale Garell, M.D.
Children's Hospital
Los Angeles, California

John F. Henning, Executive Secretary-Treasurer
California Federation of Labor
San Francisco, California

Joseph Kadish, Ph.D., Acting Chief
Education Program Development Branch
National Institutes of Health, Washington, D.C.

Bernard F. Kamins
Public Relations Consultant
Beverly Hills, California

Ralph C. Kuhli, Director
Department of Allied Medical Professions and Services
American Medical Association, Chicago, Illinois

Leon Lewis, Chief
Division of Occupational Analysis and Employer Services
Manpower Administration, Department of Labor, Washington, D.C.

Walter J. McNerney, President
Blue Cross Association
Chicago, Illinois

Peter G. Meek, Executive Director
National Health Council
New York, New York

Mark J. Musser, M.D., Chief Medical Director
Department of Medicine and Surgery
Veterans Administration, Washington, D.C.

Leroy Pesch, M.D., Deputy Assistant Secretary for Health Manpower
Department of Health, Education, and Welfare
Washington, D.C.

Helen K. Powers, Education Program Specialist
Health Occupations Education
U.S. Office of Education, Washington, D.C.

Louis M. Rousselot, M.D., Assistant Secretary of Defense
Department of Defense
Washington, D.C.

William M. Samuels, Executive Director
Association of Schools of Allied Health Professions
Washington, D.C.

Dr. William Shannon, Acting Associate Executive Director
American Association of Junior Colleges
Washington, D.C.

Elizabeth Simpson, Ph.D.
Bureau of Research, U.S. Office of Education
Washington, D.C.

John D. Twiname, Commissioner, Social and Rehabilitation Service
Department of Health, Education, and Welfare
Washington, D.C.

C. Gordon Watson, D.D.S., Executive Director
American Dental Association
Chicago, Illinois

During the years of vocational education development up to World War II, many of the state teacher education programs were active in supervisory training in industry, as they realized that the products of their school-based vocational programs would eventually be employed in industry, where their success was often influenced by the skill with which the supervisor inducted them into the world of work. This interest in supervisory training has not kept pace with the increase in need for the service since World War II.

It is hoped that the favorable results reported in this study will encourage vocational educators as well as employing institutions to increase their interest and activity in the important area of training on the job.

Melvin L. Barlow, Ed.D., Director
Division of Vocational Education
University of California

ACKNOWLEDGEMENTS

The first experiment in adapting industrial "job instructor training" to the health care field as a forerunner to the Clinical Instructor Training program took place at Los Angeles County-University of Southern California Medical Center, Los Angeles. This work was made possible through the assistance of John E. Affeldt, M.D., Medical Director, Elizabeth Austin, M.D., Chairman of the Department of Physical Medicine and Rehabilitation, and Frances Patton, R.P.T., Director of Physical Therapy. Further work was done at Rancho Los Amigos Hospital, Downey, with the cooperation of Vernon L. Nickel, M.D., Medical Director, and Hazel Adkins, R.P.T., Supervisor of Physical Therapy Education. The activity continues at both institutions, and Miss Adkins' work in giving Clinical Instructor Training to physical therapists during their clinical internships has been noteworthy.

Advice in developing the program into a compact format and in preparing the method for dissemination was given by John Lyman, Ph.D., Professor of Engineering and Psychology, Bernard R. Strohm, M.A., Assistant Director, Hospitals and Clinics, and Melvin L. Barlow, Ed.D., Professor of Education and Director of the Division of Vocational Education, all of the University of California, Los Angeles; David Allen, Ed.D., Associate Director of the Division of Vocational Education (University of California) and Coordinator of Professional Resources Development (California State Department of Education, Vocational Education Section); and William M. Fowler, M.D., Chairman and Associate Professor, Department of Physical Medicine and Rehabilitation, Medical School, University of California, Davis.

Without the moral and financial support of the Department of Health, Education, and Welfare, Social and Rehabilitation Service, it would have been impossible to carry this study through to its conclusion. We are indebted for their support to James F. Garrett, Ph.D., Assistant Administrator, Cecile Hillyer, M.A., Chief, Division of Training (Retired), and Florence Linduff Knowles, R.P.T., Consultant in Physical Therapy (Retired).

During the three-year period of operation of the program a number of individuals and organizations were helpful in setting up special arrangements so the Clinical Instructor Training program might reach a wider audience. The United Nations and the Danish Government included the program as part of their Seminar for Instructors in Prosthetics for 20 rehabilitation workers from developing countries which was offered at the Orthopaedic Hospital in Copenhagen in 1969. A program at the Guam Memorial Hospital in Agana, Guam, which included personnel from the Vocational Rehabilitation Service and the Public Health Service as well as the hospital was coordinated by Sister M. Leclare, R.N., Director of Nursing Service of the hospital. An institute program to train Clinical Instructor Trainers at the Kyushu College of Rehabilitation, Kitakyushu City, Japan, was coordinated by Darlene Osborne, O.T.R., and Sadako M. deVargas, O.T.R., for two groups drawn from hospitals and rehabilitation centers in a number of Japanese cities. Their work was supported by their superiors, Tamikazu Amako, M.D., Director, Kyushu-Rosai Hospital, Masataka Ando, M.D., Principal, Kyushu College of Rehabilitation, and Takashi Akatsu, M.D., Vice Director, Kyushu College of Rehabilitation, all of Kitakyushu City, Japan.

Two hospital associations were helpful in gaining acceptance of the Clinical Instructor Training program by their member hospitals. The Hospital Association of Hawaii, under the direction of Ollie Burkett, Executive Director, recommended the program to all member hospitals. As a result, the majority of hospitals, health care institutions, and rehabilitation centers in the Islands sent staff members to the classes that were offered. The task of coordinating enrollments and setting up schedules was handled by Ernest E. Bertelotti, Head, Continuing Education, School of Public Health, University of Hawaii, Honolulu.

The Hospital Council of Southern California, through the cooperation of John B. Brewer, Executive Director, and Frank St. Denis, Assistant Executive Director, recommended the program to the member hospitals, with the result that 18 participated. The experience with the two hospital associations added to the scope of the study by providing some indication of the part such organizations could play in case an effort was to be made to spread the program widely.

The report was edited by Mary H. Ellison and typed for reproduction by Charilyn Johnston, both staff members of the Allied Health Professions Projects of the Division of Vocational Education, University of California.

Miles H. Anderson, Ed.D.
Director, Clinical
Instructor Training

September 1, 1971

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THE CLINICAL INSTRUCTOR TRAINING PROGRAM: DEVELOPMENT, OPERATION, EVALUATION

INTRODUCTION

The major objective of the Clinical Instructor Training Program is to improve rehabilitation services for handicapped people by providing efficient on-the-job training to develop workers who will provide these services. An equally important objective is to provide an effective means for getting unemployed people off the welfare rolls and into the health care force by providing on-the-job training to make it possible for them to get and hold jobs.

The program accomplishes these objectives by teaching people in health care institutions how to organize an in-service training program and how to instruct on the job. The methods and procedures presented are reasonably simple, and the amount of time required is 12 hours for a class of 12.

The three years of experience with the program have shown that health care manpower development efforts seldom succeed without an on-the-job training component. Graduates of professional schools, such as nurses and physical therapists, must receive extensive on-the-job training ("clinical practice," "internship," etc.), before they are fully acceptable and effective as professionals. This is doubly true of occupations with few if any school programs, such as hospital housekeeping, laundry work, engineering maintenance, and food service. On-the-job training in the hospital is the only way these and similar jobs can be learned. Since these occupations are the ones offering most of the entry-level assignments that are easiest for the unemployed welfare recipient to learn, it is clear that more and better on-the-job training is potentially one of the most important factors in getting the unemployed off the welfare rolls and into jobs.

"Clinical Instruction" is a synonym for "on-the-job" instruction in the health care setting and is used primarily to differentiate it from job instruction in industry. Unfortunately, many people have assumed it meant that only hospital staff involved in direct patient care is eligible to participate in Clinical Instructor Training. It has required considerable effort to get acceptance of the idea that on-the-job instruction is just as important in the supportive occupations in the hospital as for those involving patient care. The expression "on-the-job" leaves little doubt as to the aim of the program.

On-the-job instruction in health care facilities is often conducted on a hit-or-miss basis, which results in waste of time and materials, poor quality patient care, and dissatisfaction on the part of the new employee. The four main causes of poor quality on-the-job instruction are, first, relegation of training to a low priority in the array of pressing responsibilities of the busy department supervisor; second, inability of many supervisors to understand how on-the-job training can be accomplished effectively on an individual instruction basis in the small amount of time available in a busy department; third, a tendency for supervisors to associate training with formal classroom "school" instruction, which they feel is impractical in a

hospital; and fourth, the lack of a systematic method for doing on-the-job training that will assure more learning in less time with greater retention.

Because of these ineffective practices and ill-founded assumptions, on-the-job training is frequently neglected and its potential for solving our health manpower and welfare problems is lost. The Clinical Instructor Training Program attempts to reverse this situation. Every effort is made to convince the supervisor that training is one of his major responsibilities, a part of his job, and that his success as a supervisor depends to some extent on how well his staff is trained, since the supervisor gets results through people. His on-the-job training activities enjoy increased status and respect when he is officially certificated and recognized as a clinical instructor. All of these factors, in turn, help create an organized "in-service training program" atmosphere that greatly improves the trainees' morale and motivation by giving them the feeling that they are being helped to develop themselves in a systematic way.

Clinical Instructor Training encourages supervisors to take on the difficult tasks of training disadvantaged personnel and welfare cases. As they develop more and more confidence in the instructional system they have been taught to use they become convinced that good on-the-job instruction does not require excessive time, does produce results, and is a pleasant and rewarding experience.

In addition to its value as a means for more effectively training new health workers, Clinical Instructor Training has proven useful in upgrading experienced workers by teaching them more advanced procedures. It also is a means of teaching patients to care for themselves properly after leaving the hospital, and of teaching members of patients' families to care for them in cases where the patient is unable to do so for himself. This broad application for teaching skills suggests that training in <u>how to teach</u> is useful for all personnel engaged in patient care, not just those involved in supervision.

A major problem in health care delivery is the critical need for rapid expansion of the Allied Health Professions. Evidence of this need has been gathered by means of a number of studies. The following excerpts from Congressional Reports are typical:

1. <u>House Report No. 1628, 89th Congress 2nd Session,</u> p. 6, As health care becomes more complex, and as demands for health care increase, all of the functions of care cannot be performed by the doctors and dentists themselves. The supply of doctors, dentists, and other highly trained professionals simply cannot be expanded sufficiently to meet these needs. A large number of allied professional and technical workers will be required to extend the reach of physicians and dentists. Looking ahead 10 years, we can see that the supply of physicians will be about the same as it is today in relation to population. Our hopes and needs to provide the best in health care for the American people can be fulfilled only to the extent that it is possible to increase the numbers and capabiilities of allied health workers.

2. Senate Report No. 1722, 89th Congress 2nd Session, p. 2. Present supply of personnel in 7 typical allied health professions is 159,200; the estimated need by 1975: 365,000.

If the number of people in the allied health professions must be more than doubled by 1975, it is clear that much of this training must be done in hospitals, on the job. The number of those to be trained in this way should be tripled. The need for better and more efficient on-the-job training is clear in view of these facts.

An important aspect of the problem is the fact that while there is a shortage of skilled personnel in the health care occupations, at the same time the country is burdened with a significant number of unemployed adults and youths who must be maintained at public expense. A substantial number of these welfare recipients are disadvantaged individuals who cannot readily qualify for any of the various allied health professions school programs. Such people do have a chance to succeed in a hospital entry-level job if effective on-the-job training in the hospital can be provided.

As contrasted with industry, where on-the-job training has been widely accepted as a part of the normal responsibility of the supervisor, hospitals and health care institutions in general have relatively little organized on-the-job training. This appeared to be the situation in 1968 and was a major factor in getting the Clinical Instructor Training program under way as a research and development project to determine if the problems of health manpower shortages and overpopulated welfare rolls could be solved or at least alleviated by introducing efficient on-the-job teaching techniques.

ABSTRACT

A study was undertaken to learn if on-the-job training of allied health personnel could be improved by offering supervisors a short seminar in techniques of teaching. A twelve hour program called "Clinical Instructor Training" was developed for this purpose, and 1,299 participants were trained during a three year period.

To evaluate results, a survey was made by mailing questionnaires to those participants who could be located, resulting in 429 responses. Over 80 percent felt the program was outstanding or well done, and an equal number indicated that as a result of the program, patient care had been improved to some extent.

The results of the study indicate that Clinical Instructor Training should be continued and expanded, and that similar short seminars in other aspects of human relations, supervision, leadership, and management should be prepared and offered in the health care field.

DEVELOPMENT OF THE PROGRAM

For many years, supervisors in industry have been trained in techniques of on-the-job instruction through short seminars commonly known as "Job Instructor Training" and often referred to as simply "J.I.T." The J.I.T. program was an important factor in providing adequate new manpower for war industries during World War II, when thousands of foremen and supervisors were taught how to instruct on the job through the 10 hour J.I.T. sessions. In one form or another, it has continued as a part of most industrial supervisory training programs. When tried out in hospitals, however, the industrial version was not well accepted by health care personnel, as the terms used and the examples given were not readily related by them to their work in hospitals.

The J.I.T. program was rewritten to adapt it to the health care occupations and tried out in several hospitals in Southern California, the University of Washington Medical School, and the Duke University Medical School. After each tryout, it was revised until it functioned smoothly. The result was the Clinical Instructor Training Program Trainer's Manual, the 2x3 inch "How to Instruct" card (Appendix A), and the "Job Breakdown Sheet" (Appendix B).

The content of the program was refined many times during the three-year grant period, but the basic format has remained unchanged. In 1970, the Trainer's Manual was translated into Spanish by the World Health Organization in Mexico City, and into Japanese by the staff of the Kyushu College of Rehabilitation in Kitakyushu City, Japan. Both translations have been published and are available. As a result of this work, a number of physical therapists were trained by the World Health Organization to give the course in Spanish, and this activity is being carried on in a number of countries in Latin America. Similar results were obtained in Japan, where two institute-type programs were given for trainers at Kyushu College of Rehabilitation.

An outline of the Clinical Instructor Training program appears on the following pages:

CLINICAL INSTRUCTOR TRAINING PROGRAM

SESSION I. THE FOUR STEP METHOD OF INSTRUCTION--2 HOURS

1. The role of members of the Allied Health Professions in rehabilitation and health care, and their relationships with one another and with members of the medical and dental professions.

2. The importance of the role of members of the Allied Health Professions in rehabilitation and health care today.

3. The purposes and importance of clinical instruction for members of the Allied Health Professions.

4. The need for increased efficiency and better organization in clinical instruction.

5. Demonstrations of faulty instruction (telling alone, showing alone, is not good instruction), followed by demonstration of the four-step method of instruction in the clinical setting, and how it increases the efficiency of clinical instruction.

SESSION II: PREPARATION FOR INSTRUCTION IN THE CLINICAL SETTING--2 HOURS

1. Preparation of a Job Breakdown for on-the-job instruction.

2. Development of an organized in-service training program and its use and importance in clinical instruction.

3. Importance of having all equipment, instruments, and materials of correct type, in good condition, and properly arranged, before starting instruction.

4. Importance of instructing in a clinical environment and under conditions as nearly as possible the same as the trainee will be expected to work in.

5. The use of the Four Tools of Instruction: Telling, Showing, Illustrating, and Questioning.

6. Assignments for practice clinical instruction.

SESSION III. HOW WE LEARN, TRANSFER OF TRAINING, PRACTICE INSTRUCTION--2 HOURS

1. Review Four Steps of Instruction, Four Tools of Teaching Four Points of Preparation for Instruction.

2. How we learn: negative and positive transfer of training and their application in clinical instruction.

3. First practice clinical instruction, followed by critique and analysis.

4. Second practice clinical instruction, critique, and analysis.

5. Personal advantages of becoming a good clinical instructor.

SESSION IV. SPECIAL INSTRUCTIONAL PROBLEMS, PRACTICE INSTRUCTION--2 HOURS

1. Using the Four Steps of Instruction in teaching a long operation; teaching a sense of "feel."

2. Four practice clinical instruction lessons, critique and analysis.

3. Additional practice instruction--2 HOURS if needed.

SESSION V. PRACTICE INSTRUCTION, SUMMARY AND REVIEW--2 HOURS

1. Four practice clinical instruction lessons, critique and analysis.

2. Review and summary of the Four Steps of Instruction, the Four Points of Preparation for Instruction, the Four Tools of Instruction. Emphasis on the personal advantages of becoming a good clinical instructor.

3. Putting the Clinical Instructor Training method into operation.

   a. Have staff conference to agree on course outline.

b. Assign specific responsibilities to clinical instructors for all teaching assignments in the course outline.

c. Instruct clinical instructors to make at least three lesson plans per week until their assignments are completed.

d. Urge consistent use of the Clinical Instructor Training Method.

e. Discuss in staff meetings the use being made of the Method.

f. Make certain of support of the Method by supervisory personnel, and urge them to systematically review its application, results, and degree of improvement in quality of clinical instruction.

g. Select clinical instructors capable of becoming Clinical Instructor Trainers, arrange for a conference for the Clinical Instructor Trainers to brief them on how to conduct the course, and provide them with the necessary manuals and instructional materials.

4. Distribute certificates and close the session.

The scheduling formats for 12 participants were (in order of popularity),

1. Three successive days, 10-12, 12:30-2:30
2. Two successive days, 8-12 or 1-5; 8-12 and 12:30-4:30
3. Three successive days, 8-12 or 1-5
4. Five successive days, 1-3

Certificates were printed on 2 1/2 x 4-inch card stock, and each participant who completed the program received one. In anticipation of the need for certificates for Clinical Instructor Trainers and for the Instructors they might train, three different versions were prepared, one for Clinical Instructors, one for Clinical Instructors to be signed by a Clinical Instructor Trainer, and another for the Clinical Instructor Trainers (Appendix C).

The practice instruction sessions were arranged to provide each participant with an opportunity to prepare a job breakdown of a task from his field and use it as a guide in teaching the task to another member of the group who was from a different occupation. This "learning by doing" activity was a form of role playing which gave the participants some practice in the techniques demonstrated. The individual practice teaching sessions were limited to 15 or 20 minutes and the small amount of time required to reach learning objectives was demonstrated satisfactorily. Teaching occupational skills on an individual instruction basis was emphasized. Little mention was made of class or group instruction, since on-the-job training seldom lends itself to this approach to teaching.

During the last 18 months of the grant period, occupational analyses, task inventories, and instructional materials developed by the affiliated Allied Health Professions Project of the UCLA Division of Vocational Education were distributed to the participants in Clinical Instructor Training sessions. These materials made the discussions of how to develop an in-service training program more functional.

The need for a non-technical rationale for learning and teaching became apparent, leading to the development of a series of ideas that provided for this need without being unnecessarily complex. These ideas were as follows:

1. Learning is what happens when a person changes his own behavior.

2. Such changes consist of either acquiring or discarding:

   a. Skills: ability to perform a task

   b. Knowledges: possession of and ability to use truth that is known to us

   c. Attitudes: how we feel about our work, colleagues, patients, and so on

3. "Discarding" or breaking old habit patterns is often ignored as a learning function, but in reality is one of the most difficult problems in education.

4. We can change our own behavior without any outside help by trial and error, experience, observation, reading, and so on. Given enough <u>time</u>, anyone with a reasonable amount of intelligence and motivation can eventually learn most occupations through this so-called "pick-up" method.

5. Teaching is helping people change their own behavior.

6. In-service training programs and schools of various kinds provide an environment where teachers can help people change their own behavior in an organized way to attain greater efficiency.

7. The chief justification for the vast sums spent on organized education is the saving in time achieved; hence, the suggested motto for hospital in-service training programs: "More learning, in less time, with greater retention."

This emphasis on the importance of time led to the practice in the Clinical Instructor Training sessions of noting the amount of time each practice teaching demonstration required, in an effort to show that organized instruction using efficient methods helps people change their own behavior in less time than would be the case if they were left to their own devices.

In the original grant proposal, one of the most important provisions was for development of Clinical Instructor Trainers who would teach Clinical Instructor Training to groups in their own institutions or geographical areas. This was to be accomplished through "Clinical Instructor Trainer Institutes" in which candidates who had taken the regular 12 hour course, and had had some experience applying it in their work, would then conduct sessions in which they would teach Clinical Instructor Training to others. In this way, a "multiplier effect" would be achieved, with the possibility of making the program self-perpetuating.

To accomplish this goal, the proposal included requests for increased funds in the second and third grant years to provide for an assistant director who would free the director to put on the "Institutes". Increased funds were not granted; in fact, funding was substantially reduced in the third year. For this reason, the program was conducted without the "Institutes". Instead, an hour at the end of each session was used to give the participants in the regular Clinical Instructor Training sessions copies of the Trainer's Manual and some orientation in how to use it in teaching the program to others. An hour of orientation is at best a superficial effort at training people to conduct a fairly complex program, yet the results of the evaluation survey showed that 32 percent of the respondents had conducted one or more sessions of Clinical Instructor Training.

OPERATION OF THE PROGRAM

The plan of operation was to go out into the field and conduct as many sessions of Clinical Instructor Training as possible, observe and listen for reactions and problems and adjust to this feedback, encourage trainees to put on the program themselves, and, finally, to make an evaluation study to arrive at some conclusions as to the results of the effort made.

To acquaint hospitals and other health care facilities with the program, a brochure was prepared and mailed to a number of institutions listed in the Guide issue of Hospitals (which includes the hospital directory of the American Hospital Association). In addition, announcements were run in health care journals and were made verbally at various meetings. Very shortly, a number of sessions were scheduled. The first was conducted at the Veterans Administration Hospital in Los Angeles for 13 participants, August 26-30, 1968. By the end of the first grant year, March 31, 1969, a total of 18 sessions had been conducted in 15 hospitals for personnel drawn from 66 different health care institutions. The total number trained was 242, representing 28 different allied health occupations. The distribution among the occupations is shown in Table 1.

TABLE 1 SUMMARY OF ENROLLMENTS IN CLINICAL INSTRUCTOR TRAINING CLASSES BY OCCUPATION FOR GRANT YEAR APRIL 1, 1968-MARCH 31, 1969

OCCUPATION	NUMBER
Registered Nurse	89
Registered Physical Therapist	32
Registered Occupational Therapist	32
Hospital Attendant	10
Licensed Vocational/Practical Nurse	14
Orthotist	8
Dietitian	8
Hospital Housekeeper	5
Medical Social Worker	5
Hospital Maintenance Engineer	4
Prosthetist-Orthotist	2
Medical Technologist/Technician	2
Cardio-Pulmonary Resuscitationist	2
Physician	2
Recreation Leader	2
Orthopedic Shoemaker	2
Anaplastologist	2
Public Health Nurse	1
Prosthetist	1
Radiology Technician	1
Pharmacist (Hospital)	1
Training Director	1
Medical Librarian	2
Editor	1
Ward Clerk	1
Vocational Rehabilitation Counselor	1
Hospital Administrator	1
Total	242

In the second grant year, April 1, 1969 to March 31, 1970, 44 sessions were conducted in 33 institutions for 527 participants drawn from 101 different health care facilities. The number of participants from each of 35 occupations is shown in Table 2.

TABLE 2 SUMMARY OF ENROLLMENTS IN CLINICAL INSTRUCTOR TRAINING CLASSES BY OCCUPATION FOR GRANT YEAR APRIL 1, 1969-MARCH 31, 1970

OCCUPATION	NUMBER
Registered Physical Therapist	149
Registered Nurse	97
Registered Occupational Therapist	42
Prosthetist-Orthotist	29
Physician	25
Business Office Worker	25
Dietitian	17
Hospital Housekeeper	17
Public Health Nurse	16
Student Physical Therapist	16
Licensed Vocational/Practical Nurse	14
Knitting Supervisor	9
Hospital Maintenance Engineer	8
Vocational Rehabilitation Counselor	7
Inhalation Therapist	7
Laundry Supervisor	6
Medical Records Technician	6
Medical Technologist/Technician	5
Pharmacist (Hospital)	4
Medical Social Worker	4
Janitor Supervisor	3
Building Service Supervisor	3
Radiology Technician	3
Physical Therapist Aide	2
Nurses Aide	2
Admissions Supervisor	2
Research Mechanical Engineer	1
Audiologist	1
Central Service Supervisor	1
Speech Therapist	1
PBX Supervisor/Instructor	1
Director of Volunteers	1
Ward Clerk	1
Training Director	1
Personnel Supervisor/Director	1
Total	527

In the third grant year, April 1, 1970 to March 31, 1971, plus a three-month extension to June 30, 1971, 43 sessions were conducted for 530 participants drawn from 128 institutions. The participants represented 45 different allied health occupations, as shown in Table 3. (The institutions from which participants were drawn are listed by grant year in Appendix D.)

TABLE 3 SUMMARY OF ENROLLMENTS IN CLINICAL INSTRUCTOR TRAINING CLASSES BY OCCUPATION FOR GRANT YEAR APRIL 1, 1970-JUNE 30, 1971

OCCUPATION	NUMBER
Registered Nurse	161
Registered Physical Therapist	64
Medical Technologist/Technician	41
Inhalation Therapist	30
Dietitian	28
Hospital Housekeeper	23
Hospital Business Manager	22
Radiology Technician	18
Physician	14
Personnel Director	11
Hospital Maintenance Engineer	11
Nuclear Medicine Technician	10
Medical Records Technician	9
Nurses Aide	7
Pharmacist (Hospital)	7
Teacher	7
Admissions Supervisor	6
Associate Director	6
Occupational Therapist	5
Training Director	4
Hospital Secretary	4
Medical Social Worker	4
Field Coordinator	4
Licensed Vocational/Practical Nurse	4
Dental Hygienist	3
Hospital Administrator	3
Operating Room Technician	2
Chief Accountant	2
Editor	2
PBX Supervisor/Instructor	2
Central Service Supervisor	2
Speech Therapist	1
Vocational Rehabilitation Counselor	1
Out Patient Supervisor	1
Recreation Therapist	1
Hospital Interviewer	1
Psychologist	1
Dental Assistant	1
Chief Cook	1
Purchasing Agent	1
Laundry Supervisor	1
Hospital Cashier	1
Hospital Insurance Clerk	1
Ward Clerk	1
EKG-EEG Technician	1
Total	530

The total of all enrollments by occupation for the entire grant period from April 1, 1968 to June 30, 1971 is summarized in Table 4.

TABLE 4 SUMMARY OF ENROLLMENTS IN CLINICAL INSTRUCTOR TRAINING CLASSES BY OCCUPATIONS FOR THREE YEAR GRANT PERIOD APRIL 1, 1968-JUNE 30, 1971

OCCUPATION	NUMBER
Registered Nurse	347
Registered Physical Therapist	245
Registered Occupational Therapist	79
Dietitian	53
Medical Technologist/Technician	48
Hospital Housekeeper	45
Physician	41
Inhalation Therapist	37
Licensed Vocational/Practical Nurse	32
Prosthetist-Orthotist	31
Business Office Worker	25
Hospital Maintenance Engineer	23
Hospital Business Manager	22
Radiology Technician	22
Public Health Nurse	17
Student Physical Therapist	16
Medical Record Technician	15
Medical Social Worker	13
Pharmacist (Hospital)	12
Personnel Supervisor/Director	12
Hospital Attendant	10
Nuclear Medicine Technician	10
Nurses Aide	9
Knitting Supervisor	9
Vocational Rehabilitation Counselor	9
Admissions Supervisor	8
Orthotist	8
Teacher	7
Laundry Supervisor	7
Associate Director	6
Training Director	6
Field Coordinator	4
Hospital Secretary	4
Hospital Administrator	4
Dental Hygienist	3
PBX Instructor	3
Central Service Supervisor	3
Building Service Supervisor	3
Janitor Supervisor	3
Ward Clerk	3
Editor	3
Chief Accountant	2
Operating Room Technician	2

Continued from preceding page.

OCCUPATION	NUMBER
Speech Therapist	2
Physical Therapist Aide	2
Medical Librarian	2
Orthopedic Shoemaker	2
Recreation Leader	2
Cardio-Pulmonary Resuscitationist	2
Purchasing Agent	1
Hospital Cashier	1
Hospital Insurance Clerk	1
EKG-EEG Technician	1
Chief Cook	1
Dental Assistant	1
Psychologist	1
Hospital Interviewer	1
Recreation Therapist	1
Out Patient Supervisor	1
Director of Volunteers	1
Audiologist	1
Research Mechanical Engineer	1
Prosthetist	1
Anaplastologist	1

A total of 1,299 participants from 63 different health related occupations is represented. The statistical data for each grant year and for the total grant period are summarized in Table 5.

TABLE 5 SUMMARY OF NUMBERS OF CLINICAL INSTRUCTOR TRAINING SESSIONS, LOCATIONS WHERE SESSIONS HELD, INSTITUTIONS PARTICIPATING, AND PARTICIPANTS, FOR GRANT PERIOD APRIL 1, 1968-JUNE 30, 1971

Grant Year	Sessions	Locations Held	Participating Institutions	Participants
1968-1969	18	15	66	242
1969-1970	44	33	101	527
1970-1971	43	41	128	530
TOTAL	105	89	295	1,299

From the data in Table 4 it is clear that more participants were from the clinical occupations (1,066, or 82%), compared to the supportive fields (233, or 18%). Of the total number in the clinical occupations, 26 percent were registered nurses, 19 percent physical therapists, 6 percent occupational therapists, 4 percent dietitians, and 3 percent medical technicians. The remaining 48 percent were spread over 58 other clinical occupations.

Of the 233 participants in the supportive occupations, 19 percent were hospital housekeepers, 11 percent business office workers, and 10 percent hospital maintenance engineers. When the Clinical Instructor Training program was planned, little consideration had been given to the needs of the supportive occupations, as indicated by inclusion of the term "clinical" in the title. After working in the hospitals with a few groups, it became clear that the work done by the supportive groups was as essential to good patient care as the clinical services. In addition, on-the-job training was the only means available for developing manpower in most of the supportive occupations, such as housekeeping and maintenance engineering. Efforts were made to obtain greater participation from the supportive groups, and some gains were made. However, the program was related by many to direct patient care occupations and it was difficult to change direction in mid-stream, so to speak.

Efforts were increasingly successful during the latter phase of the program in obtaining participation by the supportive groups. In the mixed groups, two significant advantages became apparent. First, the practice teaching sessions were more interesting to all members of the group because of the greater variety of skills introduced. Second, in many hospitals the Clinical Instructor Training sessions were the first time people from the clinical and supportive occupations had worked together in a "workshop" situation. A number of institutions reported that improvement in relations between departments was noticeable as a result of joint participation in the sessions by key departmental representatives.

Selection of institutions in which to give Clinical Instructor Training sessions was never a problem, as there were more demands than could be met, making it possible to systematically select from the applicants those that would provide the greatest range of differences, from large to small, rural to urban, and so on. Classes were scheduled in such low-population areas as Bishop, California, and Cottonwood, Arizona, as well as in heavily populated centers like Los Angeles, Chicago, and Boston. An arrangement was made with two regional hospital associations for the associations to recommend the program to their member hospitals, to determine the effectiveness of this particular promotional approach. Conclusions drawn from the experience with the Hospital Council of Southern California will be discussed in a separate report. No separate study was made of the experience with the Hospital Association of Hawaii. Suffice it to say that in operation, the Hospital Council of Southern California mailed brochures and reply cards to the members and the reply cards were forwarded to the Clinical Instructor Training office for follow-up. This effort started April 1, 1970 and resulted in sessions being scheduled in 18 hospitals in Southern California.

Costs of Operating the Program

The cost of operating a research and demonstration program is an important consideration, as there may be implications for amounts of funds that may be needed to finance further expansion of the program if that is deemed advisable. The costs are shown in Table 6.

TABLE 6 OPERATING COSTS, CLINICAL INSTRUCTOR TRAINING PROGRAM: 1968-1971

Grant Period	Personnel	Supplies and Travel	Overhead	Total
April 1, 1968 to March 31, 1969	29,000	5,800	2,784	37,584
April 1, 1969 to March 31, 1970	30,504	6,000	2,920	39,424
April 1, 170 to March 31, 1971	28,600	3,000	2,528	34,128
Extension to Aug. 31, 1971	7,700	1,500	736	9,936
TOTAL	95,804	16,300	8,968	121,072

If $121,072 was the total cost of all phases of the Clinical Instructor Training Program, the number of sessions conducted was 105, and the number of participants trained was 1,299, the cost per session of average size (12.3 participants for 12 hours) is $1,153. The cost per trainee is $93.70, and the cost per trainee hour is $7.80.

The normal three-year grant period orginally planned ended March 31, 1971. Because of the reduction in funds in the 1970-1971 grant year, there was no money available to defray costs of an evaluation survey and final report. Additional time and funds were requested, and the grant was extended as indicated in Table 6. The additional funds were used to prepare an evaluation plan and to carry out the evaluation as described in the next section.

EVALUATION

To some extent, an educational program for adults is evaluated "in the market place." If, after an initial surge, demand for it falls to zero, the logical conclusion is that the clientele has rejected it. If the program enjoys steadily growing demand after being launched it is reasonable to conclude that it provides something the clientele needs and wants. Acceptance or rejection in the market place may be a good measure of program effectiveness in general, but it does not tell the specific reasons for acceptance or rejection. For example, the participants may find some aspects of a program very beneficial, and others a waste of time, but they judge that the good parts offset the poor and support the program in general.

An approach to evaluation that will identify the strengths and weaknesses of a program will make it possible to improve a successful program and save one that seems to be a failure.

The Clinical Instructor Training program was successful in the market place, as demand for it increased each year it was offered, and is continuing. From this fact it would be easy to conclude that the program was successful in meeting a need recognized by those responsible for operating health care institutions, and that therefore the program should be continued and expanded. This approach would save time and money, but it would leave several important questions unanswered. Which parts of the program are strong and which are weak? Why was it successful? Did it improve the quality of patient care? Did it reduce waste? Did it improve employee morale? Was employee turnover reduced? Did it contribute toward more learning in less time? What skills taught were used or not used?

We might also want to know to what extent, if any, the participants put on the program themselves, or if they would be interested in doing so, and under what conditions.

Survey Participants

The amount of money and time available for evaluation of the Clinical Instructor Training program was not large enough to permit an elaborate personal interview-type fact-finding approach, but was sufficient for a mail survey. A questionnaire was written, tried out on 50 candidates, and then revised. The final version may be found in Appendix E. The questions were designed to elicit responses that could be quantified and used statistically to draw certain conclusions that would be helpful in revising and redirecting the program. Although the questionnaire was admittedly imperfect, it was decided that the cost of additional refinement would outweigh the improvement that might result, so no further changes were made.

A letter was prepared to accompany the questionnaire, explaining the purpose of the survey and asking for the respondent's cooperation. To achieve some measure of individuality, each letter was addressed and signed separately. The letter appears in Appendix F.

Each questionnaire was accompanied by the letter of explanation and a self-addressed stamped envelope to facilitate the return of the completed document.

The mailing list of the people who had participated in the program was derived from the enrollment registration forms. Many of them had moved without leaving a forwarding address and could not be located. Of the 1,299 who participated, it was possible to reach 860 with questionnaires. Of these, 454 were completed and returned, a little over 50 percent. When the deadline for starting to process the returns was reached, 429 were on hand, and the decision was made to limit the sample to that number. The 429 respondents reported working in 186 different institutions, which will be found listed in Appendix H.

Coding instructions were developed and the questionnaires were coded; then the information was punched into IBM cards. The coding instructions will be found in Appendix G. A program suitable for the purpose, the UCLA "SPSS" or "Statistical Package for the Social Sciences," was selected and the IBM 360/91 computer in the UCLA Survey Research Center was used to perform the computations. The computer print-out provided both absolute and relative (percent) frequencies for each variable.

The first eight items in the questionnaire related to the characteristics of the respondents. A summary of this information is given in Appendix I.

The majority, 92.5 percent, were employed in hospitals or Extended Care Facilities; 4.2 percent were enrolled in college or medical school. Of those employed in hospitals, 11.9 percent worked in facilities with fewer than 100 beds, 16.3 percent in hospitals with 100-199 beds, and 56.6 percent in hospitals with 200 or more beds. This is a fairly representative distribution: statistics from Hospitals, Guide Issue, August 1, 1970, (American Hospital Association), indicate that in non-profit hospitals, approximately 18 percent of personnel works in insitutions with fewer than 100 beds, 11 percent in those with 100 to 199 beds, and 71 percent in those with 200 beds or more.

As mentioned earlier, an effort was made to include enough of the smaller hospitals in the program to get at least some indication of the suitability of the Clinical Instructor Training program as a means for helping them with manpower training problems. The overall impression gathered was that small hospitals need this help as much as or more than the larger ones, as many of them are located in rural areas with few if any colleges or universities near by. For this reason, they have to depend almost entirely on their own resources for training.

The occupations represented were registered nurse, 34 percent, physical therapist, 14.2 percent, occupational therapist, 9.3 percent, business office worker, 4.7 percent, and prosthetist-orthotist, 4.7 percent, through a total of 22 occupations. The clinical occupations outnumbered the supportive groups, 90 percent to 10 percent. Since the program was aimed at those in the hospitals who had supervisory responsibilities, it was not surprising that 63 percent of the respondents reported themselves as supervisors, managers, or administrators. However, supervision is often done by personnel who do not have the title of supervisor.

Regardless of job titles, 89 percent of the respondents stated that they supervise the work of others.

Experience in their present fields of work was reported as 10 years or less by 62.4 percent of the participants, with 26.4 percent reporting six to 10 years.

Educational level attained was the Associate of Arts degree or below for 48.7 percent of those reporting, and the Bachelor of Arts degree or higher for 47.3 percent of respondents. Over 62 percent stated they had taken technical training programs related to their fields of work.

The first two questionnaire items were intended to obtain a general reaction to the total program. A strong majority (80.6%) felt the program was outstanding or well done, 16.6 percent thought it was adequate or fair, and only 0.9 percent stated they thought it was poor. This question should be an indicator of the evaluation of the marketplace, and it appears that the general reaction to the program is quite favorable. Specifically, the results were:

What is your over-all evaluation of the Clinical Instructor Training program in which you participated?

Outstanding	23.3%
Well done	57.3
Adequate	13.3
Fair	3.3
Poor	.9
No answer	1.9

The second question was aimed at the time factor, as some questions had been raised concerning the adequacy of the amount of time spent, 10 to 12 hours for 10 to 12 participants. Over two-thirds of the respondents felt the amount of time was "just about right". A few more indicated they thought the amount of time was a "bit limited" (16.1%), than thought it was "a bit too much" (12.1%). The actual response is tabulated below.

What is your opinion of the amount of time you spent in the Clinical Instructor Training Program in relation to any benefits you may have obtained?

Too much, overdone	1.6%
A bit too much	12.1
Just about right	67.4
A bit limited	16.1
Too little, inadequate	.9
No answer	1.9

The amount of time required does not seem to present a serious problem. The success of this format and time allocation could be interpreted to mean that a series of short, intensive supervisory training problems is better than one long one. Certainly, in view of the time pressures on hospital staff, the shorter session appears more likely to attract participants than a more extended one.

The remainder of the questionnaire items were included to learn the effect of the program on the individual respondents, their opinions as to its effect on key functions in their departments or areas of work, and their thoughts on how the program might be continued and expanded. Items 3 through 16 each offered a choice of four responses. The percent of the respondents choosing each response for each item is listed in Table 7, "Summary of Responses to Questions 3-16, in Percents."

Item 3 asked the participant if the teaching methods presented in Clinical Instructor Training helped him to improve his ability as an instructor. Over a third (35.0%) replied "Yes, very much." About the same number (36.1%) said, "To a large extent," and 25.4 percent said "To some extent." On this question, which touched very specifically on the major goal of the program--improvement of ability as an instructor--96.5 percent of the responses were favorable and only 1.2 percent unfavorable, with 2.3 percent not answering.

A problem often encountered in working with hospital supervisors is resistance on their part to accepting on-the-job instruction as part of the supervisor's job. An important objective of the Clinical Instructor Training program was convincing the supervisors that the ability to instruct well was an important factor in successful supervision. Item 4 asked the respondent if he felt that his participation in the program had influenced him to increase his acceptance of training as a part of his regular job responsibility. "Yes, very much," replied 25.6 percent of the respondents; "To a large extent," said 27.7 percent; "To some extent," 30.8 percent; "No, not at all," 10.7 percent; and No answer 5.2 percent. In summary, favorable responses were given by 84.1 percent, indicating that much of the resistance to accepting responsibility for on-the-job training had been overcome. The commonest reason given during the training sessions for reluctance to assume responsibility for training was lack of time, which led to re-emphasizing the time-saving advantages of well-trained workers, and the demonstrable fact that efficient training methods shorten the time needed to train effectively.

One of the most potent motivating forces in health care work is the desire to be of help to one's fellow man. To take advantage of this desire it is necessary to tie all hospital occupations to the mission of the institution, which is patient care and helping the patient to get well. This is easy with nurses, but difficult with housekeepers and maintenance engineers, who do not readily see a cause-and-effect relationship between their work and patient care. Item 5 attempted to discover how the respondents felt about the possibilities that Clinical Instructor Training techniques were improving patient care, and 47.1 percent said it was improved "To some extent." In the two more favorable categories, 37.1 percent felt that the program helped improved patient care "very much" or "to a large extent." A negative response was made by 6.8 percent and 9.0 percent did not answer this question.

A common pitfall in supervisory training is failure of higher-level management to support the line supervisors in their efforts to apply techniques learned in supervisory training programs. Item 6 asked the respondents if they believed their efforts to apply the techniques taught in Clinical Instructor Training were supported by their superiors.

One-third (33.1%) said "Yes, very much," while 28.9 percent said "To a large extent," and 25.9 percent, "To some extent." Positive responses totaled 87.9 percent and negative responses and "No Answer" were only 12.1 percent. Apparently the Clinical Instructor Training program is supported by nearly all hospital administrators and their lieutenants, in the institutions represented by the questionnaire respondents.

The Clinical Instructor Training program is useless if the participants do not accept and use the "Four Steps of Instruction" that summarize the teaching techniques presented in the sessions. Item 7 was included in the questionnaire to learn if the participants had found that using the "Four Steps of Instruction" made instruction easier for them. Nearly half (44.5%) replied "Yes, very much," and almost a third (31.9%) said "To a large extent." "To some extent" drew an 18.6 percent response, with "No, not at all," 2.3 percent, and 2.7 percent not answering. A 95 percent favorable response to this key question would indicate that the "Preparation, Presentation, Application, Test" teaching pattern was learned, retained, and successfully used by a surprisingly large porportion of the respondents.

In developing the Clinical Instructor Training program, efforts were made to build into it elements that would not only help the supervisor develop the ability to teach on the job, but also would make him more aware of training problems in his area of responsibility. Item 8 asked the respondent if his participation in the program had caused him to give more attention to such problems. One-third (33.6%) replied "Yes, very much." Over one third (36.1%) said "To a large extent," and about one-fourth (24.2%) said "To some extent," with 4.2 percent negative responses and 1.9 percent not answering. With 93.9 percent responding favorably, it would seem clear that the program was effective in getting the supervisors to be more aware of training problems in their areas of responsibility.

Since the passage of legislation in 1965 to promote the increase in numbers of allied health personnel, there has been an upsurge in the numbers of institutions of higher education offering instructional programs in various allied health occupations. It is impossible for a college to train anyone for a patient care occupation without providing the student with an opportunity to learn patient care by working with patients under the supervision of a professional. The colleges can provide "simulated" experiences with plastic dummies and the like, but, while helpful, such experiences are transitory, leading to the real thing--working with a live patient. Patients are mostly found in hospitals, so it is necessary for the colleges to arrange for periods of "clinical experience" for their students in neighboring hospitals to give them the opportunity to work with real patients. In setting up the Clinical Instructor Training program, it was thought that if college students were going to learn patient care in the hospitals, it would be helpful if the hospital staff members responsible for their guidance received some instruction in how to teach, and that the program might fill this need. A number of colleges promoted Clinical Instructor Training sessions specifically for the clinical instructors in in their affiliated hospitals. Typical of this arrangement was a session conducted at a state university, for 12 participants, none of whom was employed by the university; they were drawn from the staffs of six or seven affiliated hospitals.

In an effort to determine the effect, if any, of Clinical Instructor Training in making these joint college-hospital programs more effective, Items 9, 10, and 19 were included in the questionnaire. Item 19 was a YES/NO question aimed at learning the extent to which the respondent hospitals were affilitated with colleges in conducting educational programs. The responses indicated that 60.6 percent of the hospitals had college affiliations. Item 9 attempted to learn if Clinical Instructor Training increased the effectiveness of hospital-college joint educational programs. The response was cool, only 7.7 percent saying "Yes, very much," 14.7, "To a large extent," and 32.2 percent, "To some extent." "No, not at all" was the opinion of 19.3 percent, and 26.1 percent did not answer this item. Slightly over half (54.6%) of the respondents replied favorably, while almost a fifth (19.3%) of response was negative.

After working with representatives of 295 hospitals and educational institutions over a three-year period, some impressions are sure to have accumulated from contacts with 1,299 participants drawn from those institutions. While not universal, a definite and apparently increasing feeling of dissatisfaction with the college-hospital arrangement was noted, particularly during the latter half of the three-year period. A number of undercurrents were sensed, such as hospital resentment of college efforts to control the total program, hospital resentment of college treatment of the clinical component as a necessary evil, college resentment of what they felt was an overly protective attitude by the hospitals regarding patients, and college resentment of hospital demands for more student time for clinical practice. Some hospital personnel harbored resentment toward the college output, as in the case of a diploma school registered nurse who was required to train a new and incompetent baccalaureate registered nurse while receiving less salary than the latter. With these impressions in mind, Item 10 was aimed at learning whether the respondents thought Clinical Instructor Training had helped improve relations between colleges and hospitals that are linked in joint educational efforts. Only 5.6 percent responded "Yes, very much," 14.2 percent said "To a large extent," 29.1 percent felt it had helped "To some extent," but 23.3 percent stated "No, not at all", and 27.8 percent did not answer. Fewer than half (48.9%) of the responses were favorable, the rest being negative or no answer at all. (It should be recalled that 39 percent of the respondents were from hospitals without a college affiliation.) The inference might be drawn that the respondents felt there was room for improvement in the relations between hospitals and colleges trying to cooperate in conducting educational programs, but that Clinical Instructor Training is not the way to achieve such improvement.

Some of the objectives of Clinical Instructor Training were to help employees learn quicker, improve their morale, and get them to stay on the job, and to cut costs through better worker performance. Items 11, 12, 13, and 16 were aimed at learning if these objectives had been attained. It is extremely difficult to determine a cause-and-effect relationship between an educational program designed to help people teach and abstract secondary outcomes such as improved employee morale and decreased turnover. This probably was reflected in the respondents' tendency to stay in the middle of the road with the preponderance of "To some extent" replies. On shortening the training time required, nearly half (41.7%) said "To some extent," 38 percent were more positive, and 20.3 percent were negative or gave no answer.

No great cost cutting effects were discernable to the respondents, with 38.9 percent admitting the training helped "To some extent," 18.5 percent more positive, 30.1 percent negative, and 12.5 percent "no answer."

In judging the effects of Clinical Instructor Training on employee morale, 45.2 percent of the respondents said they felt it helped improve it, 25.2 percent indicated "Yes, very much" and "To a large extent," while 16.3 percent were negative and 13.3 percent did not answer. Slightly more than one third (36.1%) of the respondents believed the program helped reduce employee turnover, the most of them (25.9%) in the "To some extent" column. "No, not at all" drew 40.8 percent while 23.1 percent did not answer.

The Clinical Instructor Training program in operation requires that each participant select a task from his field, make a job breakdown for it, and use this as a guide in teaching it to a member of the group who is not familiar with the job to be taught, followed by a brief critique and discussion. Each of these practice teaching exercises takes fifteen or twenty minutes and so accounts for a substantial segment of the total time allotment for the program. Item 14 was included to see if the participants felt this activity was helpful to them in their teaching. The response was positive, almost half (44.1%) being "Yes, very much," 29,4 percent responding "To a large extent," and 19.8 percent, "To some extent," with 5.8 percent "No, not at all" and 5.8 percent "no answer."

Item 15 was included as a general probe of the respondent's feelings regarding the effectiveness of the teaching techniques taught in improving training in his area of responsibility. The returns were favorable, with 88.2 percent in the three positive categories, and only 11.8 percent in the negative or no answer.

Questions 17 through 24 were YES/NO items, and the responses in percent of the total survey population may be found in Table 8.

A critical element in the Clinical Instructor Training program is the Job Breakdown. To teach a task efficiently the instructor must "program" it, that is, break it down into the "Important Steps" that are done, and the "Key Points" of knowledge that must be known to perform the "Important Steps" correctly. The result is called a "Job Breakdown." It is used as a guide by the instructor in the "Presentation Step" of the Four Steps of Instruction, which usually is a demonstration by the instructor. Making job breakdowns was found to be a difficult skill for the participants to learn, as they were all experts in their various occupations and tended to "bridge" or overlook the prosaic details without which the new learner cannot perform. Each participant made a job breakdown of a task from his own occupation and used it in his practice teaching during the session: he also practiced making breakdowns of all the teaching demonstrations observed during the teaching practice. Question 17 asked the respondents if they used some form of "Job Breakdown" in getting ready to instruct; 91.6 percent answered "Yes," 4.9 percent, "No," and 3.5 percent gave no answer. Such a high percentage of application indicates that the instruction given in Clinical Instructor Training enabled the participants to make job breakdowns and convinced them of their usefulness sufficiently to apply the technique on the job.

TABLE 7 SUMMARY OF RESPONSES TO QUESTIONS 3-16, IN PERCENTS

	Yes, very much	To a large extent	To some extent	No, not at all	No answer
3. Have you found the teaching methods presented in Clinical Instructor Training helpful in improving your ability as an instructor?	35.0	36.1	25.4	1.3	2.3
4. Do you feel that your participation in Clinical Instructor Training influenced you to increase acceptance of training as a part of your regular job responsibility?	25.6	27.7	30.8	10.7	5.2
5. Do you believe the application of Clinical Instruction techniques has helped improve patient care in your area?	15.4	21.7	47.1	6.8	9.0
6. Do you believe your efforts to apply the techniques of Clinical Instruction are supported by your superiors?	33.1	28.9	25.9	4.7	7.4
7. Have you found that the use of the "Four Steps of Instruction" has made instructing easier for you?	44.5	31.9	18.6	2.3	2.7
8. Did your participation in the Clinical Instructor Training program cause you to give more attention to problems of training in your area of responsibility?	33.6	36.1	24.2	4.2	1.9
9: Do you believe participation in the Clinical Instructor Training Program has increased the effectiveness of hospital-college joint educational programs in your area?	7.7	14.7	32.2	19.3	26.1

TABLE 7 (Continued)

	Yes, very much	To a large extent	To some extent	No, not at all	No answer
10. Do you believe participation in the Clinical Instructor Training Program has improved relations between cooperating hospitals and colleges in carrying on joint educational programs?	5.6	14.2	29.1	23.3	27.8
11. Do you believe the application of Clinical Instructor Training techniques has shortened the time needed to train employees in your area of responsibility?	12.4	25.6	41.7	12.1	8.2
12. Do you believe the application of Clinical Instructor Training techniques has helped cut costs in your area of responsibility?	5.4	13.1	38.9	30.1	12.5
13. Do you believe the application of Clinical Instructor Training techniques has improved employee morale in your area of responsibility?	8.4	16.8	45.2	16.3	13.3
14. Were the practice teaching sessions helpful to you in improving your own teaching ability?	44.1	29.4	19.8	5.8	5.8
15. Do you believe the application of Clinical Instructor Training techniques has improved training in your area of responsibility?	20.3	35.0	32.9	4.2	7.6
16. Do you believe the application of Clinical Instructor Training techniques has reduced employee turnover in your area of responsibility?	2.3	7.9	25.9	40.8	23.1

TABLE 8 SUMMARY OF RESPONSES TO
QUESTIONS 17-24, IN PERCENTS

	QUESTION	YES	NO	N.A.
17.	Do you use some form of the "Job Breakdown" technique in getting ready to instruct?	91.6	4.9	3.5
18.	Do you use written course outlines as a guide for your in-service training?	72.7	20.5	6.8
19.	Does your institution participate in a hospital-college joint educational program?	60.6	32.9	6.5
20.	Should the employer pay the costs of Clinical Instructor Training for employees and have the sessions on the employer's time?	87.9	8.4	3.7
21.	Would you attend a one-day "refresher" session in Clinical Instructor Training if one was offered in your area?	81.6	15.6	2.8
22.	Have you taught Clinical Instructor Training to others?	32.4	64.8	2.8
23.	Would you be interested in putting on sessions in Clinical Instructor Training for others?	44.1	50.3	5.6
24.	If a one or two day workshop for Clinical Instructor Trainers was offered in your area would you attend?	73.4	21.4	5.2

A common fault of much on-the-job training is failure to organize the instruction so the trainee feels he is taking part in an educational program designed to help him develop his potential abilities as fully as possible. In far too many cases, the trainee feels that he is merely a member of the "labor force," and cheap labor at that. This feeling stems largely from the necessity for teaching tasks as the need for them is noted, on a random basis, rather than in logical sequence. The day-to-day requirements of the job often determine what will be taught, and when, rather than any pre-planned program of instruction. However, if the total number of tasks to be taught the trainee is listed in a course outline, with space for signature of instructor and date opposite each task, this outline can be given to the trainee with instructions to see that the record of his progress is kept up to date.

Having a written course outline and knowing how he is progressing in it causes the trainee to feel that he is pursuing an organized educational program. When the effort is made to do this, the improvement in the trainees' morale and in the speed of their progress is remarkable.

In the "How to get ready to instruct" phase of the Clinical Instructor Training program, efforts were made to get the participants to prepare such course outlines for use in their own departments. Occupational analyses and task inventories were given to them, from which they could select the tasks that would be appropriate to their particular needs. Question 18 was included to determine how successful this effort was. To the question "Do you use written course outlines as a guide for your in-service training?" 72.7 percent of the respondents replied "Yes," 20.5 percent, "No," and 6.8 percent did not reply.

Preparing a course outline and putting it into practice is technically difficult to achieve; if nearly three-fourths of the respondents were able to do so, the Clinical Instructor Training program proved reasonably effective in that area.

Item 19 checked on whether the hospital employing the respondent was affiliated with a college in a joint educational program, as mentioned earlier.

The remaining YES/NO questions were included to learn what the respondent thought about putting on some classes in Clinical Instructor Training himself, and details of his ideas on fees, potential attendance, and other matters.

Item 20 asked whether the employer should pay for the cost of Clinical Instructor Training for the employees, and if the program should be conducted on the employer's time. To this the respondents said "Yes," 87.9 percent; "No," 8.4 percent; and no answer, 3.7 percent. This is actually the prevailing policy throughout most of the United States, and in the few instances when the employees were required to personally defray the costs or to attend on their own time, their attitude was adversely affected.

The suggestion that a one-day refresher course be offered has been received from a number of participants in Clinical Instructor Training sessions given

during the first two years of the grant period. Question 21 asked if the respondent would be interested in attending such a refresher course if one was offered in his area. The response was 81.6 percent "Yes," 15.6 percent "No," and a 2.8 percent failed to answer. Such a high positive reaction would lead to the conclusion that any future planning for extending the Clinical Instructor Training program should include provision for short refresher courses for past participants.

As mentioned earlier, the original program planning included arrangements for "Institutes" at which to teach selected candidates to become Clinical Instructor Trainers. Since funds were not made available for this work, each Clinical Instructor Training session was ended with a brief orientation on how to put on the program. Copies of the Trainer's Manual were given to the participants, and they were encouraged to try giving the program to people in their own departments. In view of these circumstances, it was surprising that in response to Item 22, almost one-third (32.4%) of the respondents said they had taught Clinical Instructor Training to others. In aswer to the question, "Would you be interested in putting on sessions in Clinical Instructor Training for others?" 44.1 percent answered "Yes," 50.3 percent "No," and 5.6 percent failed to answer.

Question 24 asked if they would attend a one or two-day workshop for Clinical Instructor Trainers (the "Institute" idea): 73.4 percent said "Yes," 21.4 percent, "No," and 5.2 percent failed to answer. Apparently a few more were interested in participating in a workshop to train Trainers than were interested in putting on sessions as Trainers, possibly with the idea that they would gain personally from the experience.

Through correspondence requesting instructional materials, certificates, and other supplies, it is known that approximately 50 Clinical Instructor Trainers are putting on sessions in various hospitals. An outstanding instance is Children's Hospital of Los Angeles, where six Trainers have trained over 150 participants since October, 1968.

Summaries of responses to questions 25 through 30 will be found in Table 9.

Question 25 was an attempt to arrive at some consensus as to the amount of compensation a Clinical Instructor Trainer should receive for conducting a 12 hour session for 12 people. The respondents who were not interested in this activity apparently did not answer the question (45.3%). Of those who did, 20 percent favored $100 to $199, 15 percent specified $1 to $99; 7.7 percent chose $200 to $299. The majority choices are low by comparison with fees received for supervisory training courses offered by various agencies active in that field, such as the American Management Association. This would indicate that the respondents are inexperienced in this area of work, and tend to undervalue the worth of their services. As a practical guide in setting fees, this information would be of limited value.

In an effort to learn to what extent training had been done by those who reported having conducted Clinical Instructor Training sessions, question 26 asked the approximate total number of participants they had had in their classes. Apparently the greatest number completed only one session, and then stopped, as 74 respondents or 17 percent of the total had trained 1-12 individuals. Thirteen respondents (3.0%) trained 13-20, eight (1.7%)

trained 21-50, and four (1.2%) trained 51-150. Note that 325 (75.8%) did not answer this question. The total number reported trained by the respondents was 1,300. No evaluation of the effectiveness of this training was possible.

Question 27 "From what occupations were most of them" was included in an effort to discover the range of occupations covered in the sessions held by respondents. Response could not be coded, however, so no results are reported.

In an effort to get an estimate of the amount of demand that might be anticipated for Clinical Instructor Training, Item 28 asked each respondent his estimate of the number in his area who might want to participate in the program. Almost three-fourths (73.7%) gave no answer or did not know. Of the 113 who did answer, 84 (19.5%) said 1-49; nine (3.1%), 50-99; and 20 (4.7%), 100-499. The total number of potential participants reported by the 113 respondents answering the question is 5,050. The information received in response to this question is inconclusive, however, and other means would have to be found to obtain more useful estimates of the potential demand for the program.

Question 29 was aimed at finding out how much the respondents thought employers would be justified in paying per employee to have them participate in Clinical Instructor Training, in addition to released time. While a third (33.7%) of the respondents did not answer the question or "Didn't know," equal numbers (73--17.0%), suggested $15 and $25. Some thought the employer should pay nothing (62--14.5%); 41 (9.6%) believed $50 was justified. The last question asked the respondent how much he would be willing to pay to attend a Clinical Instructor Training program on his own time. As in the previous question, $15 and $25 were the amounts most frequently selected, with the latter slightly ahead: $15, 109 (25.5%); $25, 113 (26.3%). Almost as many were willing to pay $50 themselves as thought the employer should pay that much, and two were willing to go $200 themselves, but only one thought the employer should pay that amount.

As noted earlier, the responses to the questions on fees and costs are not realistic, but they should make people in supervisory training aware of the fact that they cannot take it for granted that hospital personnel will accept more realistic values without considerable effort on their part in presentation of facts and figures to justify higher costs and fees.

Table 9 SUMMARY OF RESPONSES TO QUESTIONS 25-30, BY NUMBER AND PERCENT
(N=429)

Question	Response	Number	Percent
25. What sum would you consider as a fair compensation for teaching a standard Clinical Instructor Training Program of 12 hours for 12 people?	$1-$99	66	15.0
	100-199	86	20.0
	200-299	33	7.7
	300-599	31	7.2
	600-899	11	2.5
	Don't know	10	2.3
	No answer	192	45.3
26. If you have taught some sessions of Clinical Instructor Training for others, what was the approximate number who attended.	1-12	74	17.1
	13-20	13	3.0
	21-50	8	1.7
	50-150	4	1.2
	Don't know	5	1.2
	No answer	325	75.8
28. How many allied health occupations personnel would you estimate might be interested in participating in standard Clinical Instructor Training sessions in your area?	1-49	84	19.5
	50-99	9	3.1
	100-499	20	4.7
	Don't know	35	8.2
	No answer	281	64.5
29. How much do you believe your employer would be justified in paying per employee to attend a 12-hour Clinical Instructor Training program in addition to released time?	0	62	14.5
	$5	17	4.0
	$15	73	17.0
	$25	73	17.0
	$50	41	9.6
	$75	13	3.0
	$100	3	.8
	$200	1	.2
	$500	1	.2
	Don't know	38	8.8
	No answer	107	24.9
30. What is the most you would be willing to pay to attend a standard Clinical Instructor Training program if your employer would not pay the costs and you had to attend on your own time?	0	39	9.1
	$5	30	7.0
	$15	109	25.5
	$25	113	26.3
	$50	38	8.9
	$75	8	1.9
	$100	4	.9
	$200	2	.5
	Don't know	6	1.4
	No answer	80	18.5

The last page of the questionnaire provided space for any comments the respondents might care to make. Most of them took advantage of this opportunity. As a result, there are so many it would not be practical to reproduce all of them. Since many expressed the same ideas an attempt was made to select some that were typical. In addition, an effort was made to present a fair proportion of negative comments as well as those extolling the virtues of the program. These comments may be found in Appendix J.

A recurring suggestion in the comments related to the need for supervisory training programs in other areas of management such as human relations, incentives, performance evaluation, leadership, discipline, planning, and so on.

Three Clinical Instructor Training sessions were conducted in Oklahoma City and Tulsa, Oklahoma, in January, February and March, 1971. The Oklahoma Regional Medical Program sponsored this activity under the leadership of Mr. Jack White, Chief, Division of Continuing Education and Training. Mr. White's assistant, Mr. Frank W. Bexfield, Associate for Evaluation and Reveiw, prepared a questionnaire to be completed by the participants in the three programs, administered it, and summarized the results in a report. The report of Mr. Bexfield's study may be found in Appendix K, as well as the report on the program written for the "Trail Blazer", the Oklahoma Regional Medical Program news bulletin.

As part of the discussion of the extent to which the Clinical Instructor Training program is being carried on by Trainers in the various hospitals where the program has been introduced, the activity at Children's Hospital of Los Angeles has already been mentioned. The program was introduced there in October, 1968. Since that time, six resident Trainers have given the course for over 150 participants, all employees of the hospital. In December, 1970, an evaluation survey questionnaire was prepared and given to 92 of the participants in the Clinical Instructor Training program. Of these, 41 were completed and returned. A summary of their responses was prepared. The questionnaire, the report of the survey results, and a report on the program written for "Chatter from Children's Hospital", the hospital news bulletin for May, 1971, may be found in Appendix L.

SUMMARY AND CONCLUSIONS

1. The Clinical Instructor Training program was developed as a means for improving the on-the-job training of personnel for the allied health occupations. Through a program of demonstration and "learning by doing," the participants in the 12-hour seminars learned how to organize in-service training, and how to teach on the job.

2. A three year research and demonstration program was started April 1, 1968 and was completed August 31, 1971 for the purpose of evaluating the effectiveness of Clinical Instructor Training. During the three year period 1,299 participants were trained in 105 sessions conducted in 89 locations in the United States, Canada, Puerto Rico, Hawaii, Guam, Japan, and Denmark. The participants were employed in 295 different health care institutions.

3. A survey was conducted by mailing questionnaires to the 860 participants who could be located. Completed questionnaires were returned by 429 of them. The information was reduced by computer and tabulated.

4. Over 90 percent of the respondents were employed in hospitals. The most numerous participants by occupation were registered nurses, followed by registered physical therapists and occupational therapists. The majority were in supervisory positions.

5. In response to questions on the over-all value of the Clinical Instructor Training program, 80.6 percent of the respondents said it was outstanding or well done, 64.7 percent thought the amount of time spent (12 hours) was "just about right," and 37.1 percent believed the program improved patient care "very much" and "to a large extent," with 47.1 believing there was improvement "to some extent."

6. A refresher course in Clinical Instructor Training would attract 81.6 percent of the respondents; 44.1 percent expressed interest in putting on the program for others.

7. Two recommendations appeared in the comments appended to the survey instrument often enough to be worth noting: first, that the Clinical Instructor Training program should be continued and expanded; and second, that similar short, intensive seminars should be developed and offered to help supervisory personnel in the allied health occupations increase their effectiveness in other areas of supervision as well as on-the-job training.

Recommendations

1. The evidence presented in this study indicates that the Clinical Instructor Training program does indeed increase the efficiency of on-the-job training in hospitals, and therefore should be continued and expanded.

2. There is evidence of a need among allied health personnel for similar short, intensive, "learn by doing" programs in other supervisory skills, and such programs should be developed and put into operation.

APPENDIX A

"HOW TO INSTRUCT" CARDS

HOW TO GET READY TO INSTRUCT

1. **Make a Job Breakdown**
   — List important steps
   — Pick out key points (safety is always a key point)
2. **Make a Course Outline**
   — List what you expect the learner to be able to do
3. **Have the right equipment, materials and supplies**
4. **Have the workplace properly arranged**
   — Just as the worker will be expected to keep it

CLINICAL INSTRUCTOR TRAINING
for the
ALLIED HEALTH PROFESSIONS

A Service of the U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, in cooperation with the University of California at Los Angeles, Division of Vocational Education.

KEEP THIS CARD HANDY

Front

HOW TO INSTRUCT

Step 1 - PREPARATION
(1) Put him at ease
(2) State the job and find out what he already knows about it
(3) Get him interested in learning the job
(4) Place him in the correct position

Step 2 - PRESENTATION
(1) Tell, show, and illustrate one IMPORTANT STEP at a time
(2) Stress each KEY POINT
(3) Instruct clearly, completely, and patiently, but no more than he can master

Step 3 - APPLICATION
(1) Have him do the job, correct errors
(2) Have him do the job again as he explains each KEY POINT to you
(3) Ask questions to make sure he understands
(4) Have him do the job over until YOU know HE knows

Step 4 - TEST
(1) Put him on his own
(2) Ask questions on key points
(3) Check frequently, praise good work, reinstruct to correct poor work

IF THE LEARNER HASN'T LEARNED, THE INSTRUCTOR HASN'T TAUGHT.

Back

APPENDIX B

U.C.L.A. DIVISION OF VOCATIONAL EDUCATION
CLINICAL INSTRUCTOR TRAINING PROGRAM
JOB BREAK-DOWN SHEET

Instructor: _____ Trainee: _____ Job: _____

IMPORTANT STEPS IN THE OPERATION: A logical segment of the operation when something happens to ADVANCE the work	KEY POINTS: Anything in a step that might Make or break the job Injure the worker Make the work easier, i.e., "knack," "trick," special timing, bit of special information

APPENDIX C

CERTIFICATES

UNIVERSITY OF CALIFORNIA, LOS ANGELES
DIVISION OF VOCATIONAL EDUCATION
IN COOPERATION WITH
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE

THIS CERTIFIES THAT

_____

HAS SUCCESSFULLY COMPLETED A 10-12 HOUR
COURSE IN CLINICAL INSTRUCTOR TRAINING
AND IS QUALIFIED
CLINICAL INSTRUCTOR

DATE_____

SIGNED_____

CERT. NO._____ TRAINER

Clinical Instructor Certificate

UNIVERSITY OF CALIFORNIA, LOS ANGELES
DIVISION OF VOCATIONAL EDUCATION
IN COOPERATION WITH
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE

THIS CERTIFIES THAT

_____

HAS SUCCESSFULLY COMPLETED A 10-12 HOUR
COURSE IN CLINICAL INSTRUCTOR TRAINING
AND IS A QUALIFIED
CLINICAL INSTRUCTOR

Miles N. Anderson

_____
DIRECTOR, CLINICAL INSTRUCTOR TRAINING

DATE_____

SIGNED_____

CERT. NO _____ TRAINER

Clinical Instructor Certificate
for C.I.T. Trainers

UNIVERSITY OF CALIFORNIA, LOS ANGELES
DIVISION OF VOCATIONAL EDUCATION
IN COOPERATION WITH
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE

THIS CERTIFIES THAT

_____

HAS SUCCESSFULLY COMPLETED CLINICAL
INSTRUCTOR TRAINING, INSTITUTE TRAINING
AND COACHING, AND IS A QUALIFIED
CLINICAL INSTRUCTOR TRAINER

DATE_____ SIGNED_____

CERT. NO _____ PROJECT DIRECTOR
CLINICAL INSTRUCTOR
TRAINING PROGRAM

Clinical Instructor Trainer Certificate

APPENDIX D

INSTITUTIONS FOR WHICH PERSONNEL WERE TRAINED
IN CLINICAL INSTRUCTOR TRAINING PROGRAMS
April 1, 1968 to March 31, 1969

Aidmore Crippled Children's Hospital	Atlanta, Georgia
American Rehabilitation Foundation	Minneapolis, Minnesota
Atlanta Brace Shop	Atlanta, Georgia
Baroness Erlanger Hospital	Chattanooga, Tennessee
Childrens Hospital of Los Angeles	Los Angeles, California
East State Hospital	Medical Lake, Washington
Emory University Medical School	Atlanta, Georgia
Fairview Hospital	Minneapolis, Minnesota
Georgia Retardation Center	Atlanta, Georgia
Georgia Warm Springs Foundation	Warm Springs, Georgia
Grady Memorial Hospital	Atlanta, Georgia
Hawaii County	Honokaa, Hawaii
Hawaii Health Department	Hilo, Hawaii
Hawaii State Health Department	Honolulu, Hawaii
Hawaii Heart Association	Honolulu, Hawaii
Hawaii State Hospital	Honolulu, Hawaii
Hennepin County General Hospital	Minneapolis, Minnesota
Hilo Hospital	Hilo, Hawaii
Honolulu Department of Health	Honolulu, Hawaii
Kahala County Hospital	Hawi, Hawaii
Kaiser Foundation Hospital	Honolulu, Hawaii
Kaukini Hospital	Honolulu, Hawaii
Kida Nursing Home	Honolulu, Hawaii
Kona Hospital	Kealakekua, Hawaii
Kula Sanatoria	Wailukui and Kula, Hawaii
Lake Area Vocation-Technical School	Watertown, South Dakota
Lanai Community Hospital	Lanai City, Hawaii
Leahi Hospital	Honolulu, Hawaii
Lossing Orthopedic Brace Company	Minneapolis, Minnesota
Maluhia Hospital	Honolulu, Hawaii
Masonic Hospital	Minneapolis, Minnesota
Maui Memorial Hospital	Kahului, Hawaii
Memorial Hospital	Watertown, South Dakota
Methodist Hospital	Minneapolis, Minnesota
Molokai General Hospital	Kualapuu, Hawaii
Monroe Community Hospital	Rochester, New York
National Committee for Careers in Medical Technology	Bethesda, Maryland
Northwestern Hospital	Minneapolis, Minnesota
Pahala Hospital	Pahala, Hawaii
Queens Medical Center	Honolulu, Hawaii
Rehabilitation Center of Hawaii	Honolulu, Hawaii
St. Ann Hospital	Watertown, South Dakota
St. Francis Hospital	Honolulu, Hawaii
St. Johns Hospital	St. Paul, Minnesota

St. Mary's Hospital	Minneapolis, Minnesota
St. Mary's Junior College	Minneapolis, Minnesota
St. Paul Ramsey Hospital	Minneapolis, Minnesota
Samuel Mahelona Memorial Hospital	Kapaa, Hawaii
Sister Kenny Rehabilitation Institute	Minneapolis, Minnesota
Straub Clinic	Honolulu, Hawaii
Swedish Hospital	Minneapolis, Minnesota
University of Florida	Gainesville, Florida
University of Minnesota School of Medicine, Dept. of Physical Medicine and Rehabilitation	Minneapolis, Minnesota
University of North Carolina	Chapel Hill, North Carolina
University of Rochester, Strong Memorial Hospital	Rochester, New York
University of California, Los Angeles Child Amputee Prosthetics Project	Los Angeles, California
Veterans Administration Hospital	Atlanta, Georgia
Veterans Administration Hospital	Los Angeles, California
Veterans Administration Hospital	Minneapolis, Minnesota
Veterans Memorial Hospital	Kekaha, Hawaii
Waimano Hospital	Honolulu, Hawaii
G. N. Wilcox Memorial Hospital	Lihue, Hawaii

April 1, 1969, to March 31, 1970

Adachi Gakuen	Kitakyushu City, Japan
Alberta Hospital	Edmonton, Alberta, Canada
American University Hospital	Beirut, Lebanon
Calgary General Hospital	Calgary, Alberta, Canada
Cedars of Lebanon Hospital	Los Angeles, Calif.
Children's Hospital of the East Bay	Oakland, Calif.
Children's Hospital of Los Angeles	Los Angeles, Calif.
Division of Vocational Rehabilitation Rehabilitation Center	Rio Piedras, Puerto Rico
Easter Seal Society	Oakland, Calif.
Eden Hospital	Castro Valley, Calif.
Edmonton General Hospital	Edmonton, Alberta, Canada
Emanuel Hospital	Portland, Oregon
Fairmont Hospital	Oakland, Calif.
Franklin County Public Hospital	Greenfield, Mass.
Franklin Hospital	San Francisco, Calif.
Fuchu Institute of Rehabilitation	Tokyo-to, Fuchu City, Japan
Fukuma Hospital	Manakata-gun, Japan
The Gaylord Hospital	Wallingford, Conn.
Glenrose Hospital	Edmonton, Alberta, Canada
Goleta Valley Community Hospital	Santa Barbara, Calif.
Good Samaritan Hospital	Edmonton, Alberta, Canada
Guam Memorial Hospital	Agana, Guam
Hadassah University Hospital	Jerusalem, Israel
Hartford Hospital	Hartford, Conn.
Heritage House	Waterbury, Conn.
Hizen Hospital	Kanzaki-gun, Japan
Industrial Hospital	Rio Piedras, Puerto Rico
International Training Center in Technical Orthopedics	Teheran, Iran
W. E. Isle Co.	Kansas City, Missouri
Knit-Rite, Inc.	Kansas City, Mo.
Kochi School of Rehabilitation	Kochi City, Japan
Kyushu College of Rehabilitation	Kitakyushu City, Japan
Kyushu Rosai Hospital	Kitakyushu City, Japan
Kyushu Kosei Nenkin Hospital	Kitakyushu City, Japan
Kyushu University	Onsen Kenkyu-sho, Beppu City Japan
Laguna Honda Hospital	San Francisco, Calif.
Marcus J. Lawrence Memorial Hospital	Cottonwood, Arizona
Letterman General Hospital	San Francisco, Calif.
Lynnwood Auxiliary Hospital	Edmonton, Alberta, Canada
Mary's Help Hospital	Daly City, Calif.
Memorial Hospital of Long Beach	Long Beach, Calif.
Mercy General Hospital	Sacramento, Calif.
Mercy San Juan Hospital	Carmichael, Calif.
Ministry of Health	Ibodan, Nigeria
Misericordia Hospital	Edmonton, Alberta, Canada
Miyazaki Onsen Hospital	Miyazaki, Japan
Morrison Rehabilitation Center	San Francisco, Calif.
Mt. Diablo Therapy Center	Pleasant Hill, Calif.
Mt. Sinai Hospital	Los Angeles, Calif.
Mt. Zion Hospital and Medical Center	San Francisco, Calif.

National Foundation for the Rehabilitation of the Disabled	Athens, Greece
	Quezon City, Philippines
National Orthopaedic Hospital	Tokyo, Japan
National Rehabilitation Center for the Handicapped	Buenos Aires, Argentina
National School for Prosthetics and Orthotics	New Britain, Conn.
New Britain Memorial Hospital	Bishop, Calif.
Northern Inyo Hospital	Kano, Nigeria
Orthopaedic Hospital, Ahmada Bello University	Copenhagen, Denmark
Orthopaedic Hospital	Kuwait
Orthopaedic Hospital	Los Angeles, Calif.
Orthopaedic Hospital	Osaka, Japan
Osaka University Hospital	Red Deer, Alberta, Canada
Dr. Richard Parsons Auxiliary Hospital	Auburn, Calif.
Placer General Hospital	Bangkok, Thailand
Pramongkutklao Hospital	Addis Ababa, Ethiopia
Prosthetic Workshop of the Fund for the Disabled	Rio Piedras, Puerto Rico
	Washington, D. C.
Psychiatric Hospital	Agana, Guam
The Psychiatric Institute	Ponce, Puerto Rico
Public Health Service	New Delhi, India
Puerto Rico Health Department	Roseville, Calif.
Rehabilitation Central Institute of Orthopedics	Edmonton, Alberta, Canada
	Hartford, Conn.
Roseville Community Hospital	Bogota, Colombia
Royal Alexander Hospital	Tokyo, Japan
St. Francis Hospital	San Francisco, Calif.
San Juan de Dios Hospital	Solo, Indonesia
School of Rehabilitation	San Juan, Puerto Rico
Shriners' Hospital for Crippled Children	Yatsuka-gun, Japan
Solo Rehabilitation Centre	Tokushima City, Japan
State Insurance Fund Medical Center	Tokyo, Japan
Tamatsukuri Seikei Geka Hospital	Norwich, Conn.
Tokushima Blind School	Oakland, Calif.
Tokyo University Hospital	San Francisco, Calif.
Uncas-on-Thames	Edmonton, Alberta, Canada
U. S. Naval Hospital	Los Angeles, Calif.
U. S. Public Health Hospital	San Francisco, Calif.
University of Alberta Hospital	Storrs, Conn.
UCLA Hospital and Clinics	Mona, Jamaica
University of California Medical Center, School of Physical Therapy	Santurce, Puerto Rico
	Burlington, Vermont
University of Connecticut School of Physical Therapy	Rocky Hill, Conn.
	Livermore, Calif.
University Hospital of the West Indies	Martinez, Calif.
University of Puerto Rico, Medical Science Campus	San Juan, Puerto Rico
University of Vermont	
Veterans Home and Hospital	
Veterans Administration Hospital	
Veterans Administration Hospital	
Veterans Administration Hospital of San Juan	

Visiting Nurse Association of San Francisco	San Francisco, Calif.
Vocational Rehabilitation Service	Agana, Guam
Workmen's Compensation Board	Edmonton, Alberta, Canada
Yale-New Haven Hospital	New Haven. Conn.
Yugawara Seikei Geka Hospital	Yugawara-Machi, Japan
Yu no Ko Hospital	Minamata City, Japan

April 1, 1970, to June 30, 1971

Alexian Hospital	San Jose, Calif.
Baptist Hospital	Oklahoma City, Okla.
Alta Bates Hospital	Berkeley, Calif.
Beth Israel Hospital	Boston, Mass.
Beverly Glen Hospital	Los Angeles, Calif.
Beverly Manor Convalescent Home	Las Vegas, Nevada
Bon-Air Hospital	Los Angeles, Calif.
Boston City Hospital	Boston, Mass.
Peter Bent Brigham Hospital	Boston, Mass.
Broadway Hospital	Los Angeles, Calif.
Calgary General Hospital	Calgary, Alberta, Canada
California Hospital	Los Angeles, Calif.
City Hospital	Saskatoon, Sask., Canada
Chedoke-McMaster Centre	Hamilton, Ontario, Canada
Chicago Medical School, University of Health Sciences	Chicago, Illinois
Chicago Wesley Memorial Hospital	Chicago, Ill.
Children's Hospital Medical Center	Boston, Mass.
Children's Memorial Hospital	Chicago, Illinois
Children's Memorial Hospital	Oklahoma City, Okla.
Clark County School District	Las Vegas, Nevada
Colorado-Wyoming Regional Medical Programs	Denver, Colo.
Cook County Hospital	Chicago, Illinois
Deer Lodge Hospital	Winnipeg, Manitoba, Canada
Desert Hospital	Palm Springs, Calif.
Desert Retreat Convalescent Home	Las Vegas, Nevada
Duke University Medical Center	Durham, North Carolina
Ecole de Readaptation, Laval University	Quebec, P.Q., Canada
Edmonton General Hospital	Edmonton, Alberta, Canada
Forsyth Dental Center	Boston, Mass.
Foothills Hospital	Calgary, Alberta, Canada
Fox River Rehabilitation Center	Chicago, Illinois
Franklin Square Hospital	Baltimore, Maryland
Glendora Community Hospital	Glendora, Calif.
Good Samaritan Hospital	San Jose, Calif.
Good Samaritan Hospital	West Islip, New York
Halifax Infirmary	Halifax, N.S., Canada
Harbor General Hospital	Torrance, Calif.
Hartford Hospital	Hartford, Conn.
Heritage House Nursing Home	Waterbury, Conn.
Hillcrest Medical Center	Tulsa, Okla.
Hope Hall Convalescent Home	Waterbury, Conn.
Hotel Dieu Hospital	Kingston, Ontario, Canada
Imperial Hospital	Inglewood, Calif.

Inter-Community Hospital	Covina, Calif.
Jewish Convalescent Hospital	Laval, P.Q., Canada
Lawrence Memorial Hospital	Medford, Mass.
Little Company of Mary Hospital	Chicago, Illinois
Little Company of Mary Hospital	Torrance, Calif.
Loma Linda University School of Health Related Professions	Loma Linda, Calif.
Long Island Jewish Medical Center	New Hyde Park, New York
Martin Luther Hospital	Anaheim, Calif.
Lutheran General Hospital	Chicago, Illinois
Mary's Help Hospital	Daly City, Calif.
Massachusetts General Hospital	Boston, Mass.
Meadowbrook Hospital	East Meadow, New York
Medical Center of El Monte	El Monte, Calif.
Mercy Hospital	Oklahoma City, Okla.
Montreal Children's Hospital	Montreal, P.Q., Canada
Morningside Hospital	Los Angeles, Calif.
Mt. Sinai Hospital	Chicago, Illinois
Nassau County Medical Center	East Meadow, New York
Nevada Nurses' Association	Las Vegas, Nevada
New England Baptist Hospital	Boston, Mass.
New England Deaconess Hospital	Boston, Mass.
New England Medical Center Hospitals	Boston, Mass.
Northeastern University	Boston, Mass.
Northwestern University	Chicago, Illinois
Nova Scotia Rehabilitation Center	Halifax, N.S., Canada
O'Connor Hospital	San Jose, Calif.
Oklahoma Osteopathic Hospital	Tulsa, Oklahoma
Oklahoma Regional Medical Programs	Tulsa, Oklahoma
Peninsula Hospital	Burlingame, Calif.
Redlands Community Hospital	Redlands, Calif.
Rehabilitation Institute of Chicago	Chicago, Illinois
Rehabilitation Institute of Montreal	Montreal, P.Q., Canada
Rose de Lima Hospital	Henderson, Nevada
Rose Junior College	Oklahoma City, Oklahoma
Riverside Community Hospital	Riverside, Calif.
Riverside General Hospital	Riverside, Calif.
St. Anthony Hospital	Oklahoma City, Oklahoma
St. Charles Hospital	Port Jefferson, New York
St. Francis Hospital	Tulsa, Oklahoma
St. John's Hospital	Oxnard, Calif.
St. John's Hospital	Tulsa, Oklahoma
St. Mary's of the Lake Hospital	Kingston, Ontario, Canada
St. Paul's Hospital	Vancouver, B.C., Canada
Salem Hospital	Salem, Mass.
San Bernardino Community Hospital	San Bernardino, Calif.
San Bernardino County Hospital	San Bernardino, Calif.
San Bernardino Hospital	San Bernardino, Calif.
San Pedro and Peninsula Hospital	San Pedro, Calif.
Santa Monica Hospital	Santa Monica, Calif.
Santa Paula Memorial Hospital	Santa Paula, Calif.
Schwab Rehabilitation Hospital	Chicago, Illinois
Sequoia Hospital	Redwood City, Calif.
Shaughnessy Military Hospital	Vancouver, B.C., Canada
Southern Nevada Memorial Hospital	Las Vegas, Nevada

Stanford University Medical Center	Palo Alto, Calif.
Sunrise Hospital	Las Vegas, Nevada
Swedish Covenant Hospital	Chicago, Illinois
Tampa General Hospital	Tampa, Florida
Technical Education Research Center	Cambridge, Mass.
Toronto Rehabilitation Center	Toronto, Ontario, Canada
Tulsa City-County Health Department	Tulsa, Oklahoma
Tufts-Lemuel Shattuck Hospital	Jamaica Plains, Mass.
Tufts University Dental School	Boston, Mass.
U. S. Navy Medical Center	Bethesda, Maryland
University Hospital	Saskatoon, Sask., Canada
University of Alberta	Edmonton, Alberta, Canada
University of Alberta Hospital	Edmonton, Alberta, Canada
University of British Columbia School of Rehabilitation Medicine	Vancouver, B.C., Canada
University of California, Los Angeles, Allied Health Professions Projects	Santa Monica, Calif.
UCLA Center for the Health Sciences	Los Angeles, Calif.
UCLA Medical Center Clinical Laboratories	Los Angeles, Calif.
University of California San Francisco Medical Center	San Francisco, Calif.
University of Chicago Hospital	Chicago, Illinois
University of Illinois Hospital	Chicago, Illinois
University of Manitoba, School of Medical Rehabilitation	Winnipeg, Manitoba, Canada
University of Nevada	Las Vegas, Nevada
University of Oklahoma-Oklahoma Regional Medical Programs	Oklahoma City, Oklahoma
University of Saskatchewan and Canadian Physiotherapy Association	Saskatoon, Sask., Canada
University of Saskatchewan School of Physiotherapy	Saskatoon, Sask., Canada
Veterans Administration Hospital	Northport, New York
Victoria Hospital	London, Ontario, Canada
Washington University Medical School	St. Louis, Missouri
Winnipeg General Hospital	Winnipeg, Manitoba, Canada

APPENDIX E

SURVEY OF PARTICIPANTS IN CLINICAL INSTRUCTORS TRAINING PROGRAMS

UNIVERSITY OF CALIFORNIA, LOS ANGELES
DIVISION OF VOCATIONAL EDUCATION

1. Name of facility where you now work: _____

2. Type of health care facility or educational institution in which you are currently employed:

_____Two year college

_____Four year college

_____Medical School

_____Other (specify) _____

_____Acute voluntary hospital

_____Acute proprietary hospital

_____Teaching hospital associated with a school

_____Hospital diploma or certificate program

_____Extended care facility

Size of hospital:

_____Over 200 beds _____100-199 beds _____Under 100 beds

3. Location: City _____State _____ Country _____

4. What is present occupational field _____

5. What is present position title _____

6. How many years in present field of work _____

7. Do you supervise the work of others _____

8. Educational level _____

9. Tech or training programs completed _____

1. What is your over-all evaluation of the Clinical Instructor Training program in which you participated?

   1.1 __ Outstanding; I learned a great deal.

   1.2 __ Well done; I learned a good deal.

   1.3 __ Adequate; it had average learning value for me.

   1.4 __ Fair; I learned a few things.

   1.5 __ Poor; I learned little or nothing.

2. What is your opinion of the amount of time you spent in the Clinical Instructor Training Program in relation to any benefits you may have obtained?

   2.1 __ Too much; overdone

   2.2 __ A bit too much

   2.3 __ Just about right

   2.4 __ A bit too limited

   2.5 __ Too little; inadequate

	Yes, very much	To a large extent	To some extent	No, not at all
3. Have you found the teaching methods presented in Clinical Instructor Training helpful in improving your ability as an instructor?				
4. Do you feel that your participation in Clinical Instructor Training influenced you to increase acceptance of training as a part of your regular job responsibility?				
5. Do you believe the application of Clinical Instruction techniques has helped improve patient care in your area?				
6. Do you believe your efforts to apply the techniques of Clinical Instruction are supported by your superiors?				
7. Have you found that the use of the "Four Steps of Instruction" has made instructing easier for you?				
8. Did your participation in the Clinical Instructor Training Program cause you to give more attention to problems of training in your area of responsibility?				
9. Do you believe participation in the Clinical Instructor Training Program has increased the effectiveness of hospital-college joint educational programs in your area?				
10. Do you believe participation in the Clinical Instructor Training Program has improved relations between cooperating hospitals and colleges in carrying on joint educational programs?				
11. Do you believe the application of Clinical Instructor Training techniques has shortened the time needed to train employees in your area of responsibility?				
12. Do you believe the application of Clinical Instructor Training techniques has helped cut costs in your area of responsibility.				

	Yes, very much	To a large extent	To some extent	No, not at all
13. Do you believe the application of Clinical Instructor Training techniques has improved employee morale in your area of responsibility?				
14. Were the practice teaching sessions helpful to you in improving your own teaching ability?				
15. Do you believe the application of Clinical Instructor Training techniques has improved training in your area of responsibility?				
16. Do you believe the application of Clinical Instructor Training techniques has reduced employee turnover in your area of responsibility?				

	YES	NO
17. Do you use some form of the "Job Breakdown" technique in getting ready to instruct?		
18. Do you use written course outlines as a guide for your in-service training?		
19. Does your institution participate in a hospital-college joint educational program?		
20. Should the employer pay the costs of Clinical Instructor Training for employees and have the sessions on the employer's time?		
21. Would you attend a one-day "refresher" session in Clinical Instructor Training if one was offered in your area?		
22. Have you taught Clinical Instructor Training to others?		
23. Would you be interested in putting on sessions in Clinical Instructor Training for others?		
24. If a one or two day workshop for Clinical Instructor Trainers was offered in your area would you attend?		

25. What sum would you consider as a fair compensation for teaching a standard Clinical Instructor Training program of 12 hours for 12 people? _____

26. If you have taught some sessions of Clinical Instructor Training for others, what was the approximate total number who attended?

_____

27. From what occupations were most of them? _____

_____

28. How many allied health occupations personnel would you estimate might be interest in participating in standard Clinical Instructor Training sessions in your area? _____

29. How much do you believe your employer would be justified in paying per-employee to attend a 12 hour Clinical Instructor Training program in addition to released time?

__ 0	__ $25	__ $100	_____ Other
__ $5	__ $50	__ $200	
__ $15	__ $75	__ $500	

30. What is the most you would be willing to pay to attend a standard Clinical Instructor Training program if your employer would not pay the costs and you had to attend on your own time?

__ 0	__ $25	__ $100
__ $5	__ $50	__ $200
__ $15	__ $75	__ $500

31. Please write any comments you care to concerning the Clinical Instructor Training program; what should be done about it if anything, and any other suggestions you may have that will help us decide what to do next. For instance, do you think we should develop similar short participation-type programs in other areas of personnel management for allied health personnel? If so, why? If not, why not?

_____

_____

_____

_____

_____

_____

_____

APPENDIX F

LETTER ACCOMPANYING QUESTIONNAIRE

UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

DIVISION OF VOCATIONAL EDUCATION
CLINICAL INSTRUCTOR TRAINING PROGRAM

1003 WILSHIRE BOULEVARD
SANTA MONICA, CALIFORNIA 90401

April 30, 1971

I am writing to you to ask for your help in making an evaluation study of the Clinical Instructor Training Program in which you participated.

You will recall that I started this program under a three-year grant from the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare in April, 1968, for the purpose of testing the idea that clinical instruction or on-the-job training could be made an effective means for developing allied health occupations manpower.

Since that beginning three years ago I have trained 1,299 Clinical Instructors in approximately 260 hospitals and other health care facilities. The geographical spread includes people from all regions of the United States, Canada, Puerto Rico, Guam, Japan, Hawaii, and, through the United Nations seminars in Copenhagen, a number of representatives from developing countries in various parts of the world. The Clinical Instructor Trainer's Manual has been translated into Spanish by the World Health Organization in Mexico City from where the program has been spread to various countries in South America. The Kyushu College of Rehabilitation in Japan translated it into Japanese, and it is being offered in a number of hospitals and other institutions in Japan.

The time has come to "take a reading" to learn what effect, if any, the program has had, and to get some ideas as to whether we should attempt to continue it or should drop it and work on something else. This is easier said than done when the participants are scattered all over the world, so the best I have been able to

../..

come up with is a questionnaire. I would far prefer coming to visit each of you personally to discuss what you think about the program and what we should do next. Since this is impossible, I am asking you to fill out the enclosed questionnaire and return it immediately in the stamped, self-addressed envelope provided. All information is confidential, and you need not put your name on the questionnaire unless you want to. I would appreciate it very much if you would take the time to do this immediately, as the Social and Rehabilitation Service extended the grant from April 1 to June 30 to enable me to make this survey, which leaves very little time to get the job done.

Finally, I want to say that the experience of working with all of you the past three years has been one of the most rewarding in all my years of teaching. I have never known a more earnest and dedicated group than the people in the allied health occupations. I want to thank you sincerely for your contribution to Clinical Instructor Training, and I hope that at some time in the future we may meet again.

Yours truly,

Miles H. Anderson, Ed.D.
Director
Clinical Instructor Training
Program

Enclosures

APPENDIX G

SURVEY OF PARTICIPANTS IN CLINICAL INSTRUCTORS TRAINING PROGRAMS

Coding Instructions Revised 6/9/61

VARIABLE	COLUMN	DESCRIPTION
1	1-3	Case identification number
2	4-5	01-Two year college 02-Four year college 03-Medical school 04-Other (list) 05-Acute voluntary hospital 06-Acute proprietary hospital 07-Teaching hsopital associated with a school 08-Hospital diploma or certificate programs 09-Extended care facility 10-Four year plus teaching 11-Office nurse 12- 13- 14- 15- 98-Unemployed 99-No answer
3	6	Size of hospital 1-Over 200 beds 2-100-199 beds 3-Under 100 beds 9-No answer
4	7-8	01-Nursing 02-EEG 03-Medical Records 04-Purchasing 05-Encephalographer 06-Laundry 07-Dental Hygiene 08-Nurse director and supervisor 09-Social Services 10-Dental Lab Technicians 11-Medical Pathologists 12-Inhalation therapy/Cardio-pulmonary technicians 13-Orthotics - Prosthetics 14-Food Service - Dietary 15-Ward Management 16-Engineering Maintenance 17-Medical Office - Business Office 18-Occupational therapy

VARIABLE	COLUMN	DESCRIPTION
		19-Physical therapy 20-Radiology 21-M.D. 22-Housekeeping 23-Nuclear Medical Technician 24-Pharmacy 25-ECG technicians 26-Volunteer 27-Miscellaneous 99-No answer
5	9-11	01-Supervisor/Manager 02-Administration 03-Education 04-Technical 05-Counselor 06-Student 08-Miscellaneous 99-No answer
6	12-13	As entered left zero; fill to 2 digits
7	14	1-Yes 2-No 9-No answer
8	15	Educational level 1-Less than high school diploma 2-High school diploma or equivalent 3-Some college (no degree) 4-Associate degree 5-Bachelor's degree (keep list) 6-Master's degree (keep list) 7-Other specify (keep list) 9-No answer
9	16	1-Yes-work oriented 2-Yes-not work oriented 3-None 9-No answer
1	17	1-Outstanding; I learned a great deal 2-Well done: I learned a good deal 3-Adequate; it had average learning value for me 4-Fair; I learned a few things 5-Poor; I learned little or nothing 9-No answer
3	18	1-Too much; overdone 2-A bit too much 3-Just about right 4-A bit too limited 5-Too little; inadequate 9-No answer

VARIABLE	COLUMN	DESCRIPTION
4-16	19-32	1-Yes, very much 2-To a large extent 3-To some extent 4-No, not at all 9-No answer
17-24	33-40	1-Yes 2-No 9-No answer
25	41-43	As entered. Left zero; fill to three digits 998-Don't know 999-No answer
26	44-46	As entered. Left zero; fill to three digits 998-Don't know 999-No answer
27		List
28		Same as 41-43
29	50-51	01-0 02-5 03-15 04-25 05-50 06-75 07-100 08-200 09-500 10-Other (keep list) 98-Don't know 99-No answer
30	52-53	Same as 50-51

APPENDIX H

INSTITUTIONS WHERE SURVEY RESPONDENTS ARE EMPLOYED

Alliance Medical Inns	Waterbury, Conn.
American University Hospital	Beirut, Lebanon
Atlanta Brace Shops, Inc.	Atlanta, Georgia
Avery Convalescent Hospital	Hartford, Conn.
Baptist Memorial Hospital	Oklahoma City, Oklahoma
Alta Bates Hospital	Berkeley, Calif.
Bay Harbor Hospital	Harbor City, Calif.
Beverly Glen Hospital	Los Angeles, Calif.
Black Hills Vocational Technical School	Rapid City, South Dakota
Peter Bent Brigham Hospital	Boston, Mass.
Cedars of Labanon Hospital	Los Angeles, Calif.
Cerebral Palsy Center	Ridgewood, New Jersey
Charleston Memorial Hospital	Charleston, West Virginia
Children's Hospital Medical Center	Boston, Mass.
Children's Memorial Hospital	Chicago, Illinois
Children's Hospital of Los Angeles	Los Angeles, Calif.
Department of Education, Vocational Rehabilitation Service	Agana, Guam
Department of Health, Public Health Nursing	Hilo, Hawaii
Department of Public Health and Social Services	Famuning, Guam
Duke University Medical Center	Durham, North Carolina
Eastern State Hospital	Medical Lake, Washington
Edmonton General Hospital	Edmonton, Alberta, Canada
Emmanuel Hospital	Portland, Oregon
Emory University Medical School	Atlanta, Georgia
Fairmont Hospital (Alameda County)	San Leandro, Calif.
Fairport Baptist Home	Rochester, New York
Fairview Hospital	Minneapolis, Minn.
Franklin Square Hospital	Baltimore, Maryland
Fresno Community Hospital	Fresno, Calif.
Forsyth School for Dental Hygienists	Boston, Mass.
Glendora Community Hospital	Glendora, Calif.
Glenrose Provincial General Hospital	Edmonton, Alberta, Canada
Goleta Valley Community Hospital	Santa Barbara, Calif.
Good Samaritan Auxiliary Hospital	Edmonton, Alberta, Canada
Good Samaritan Hospital	San Jose, Calif.
Good Samaritan Hospital	West Islip, New York
Grady Memorial Hospital	Altanta, Georgia
The Griffin Hospital	Derby, Conn.
Guam Memorial Hospital	Agana, Guam
Hale Makua Hospital	Wailuku, Hawaii
Harbor General Hospital	Torrance, Calif.
Hartford Hospital	Hartford, Conn.
Hartford Hospital Medical Center	Hartford, Conn.
Hartford Hospital School of Nursing	Hartford, Conn.
Hawaii Regional Medical Program, in conjunction with Hawaii Heart Association	Honolulu, Hawaii
Hillcrest Medical Center	Tulsa, Oklahoma
Hillcrest Medical Center School of Nursing	Tulsa, Oklahoma
Hilo Hospital	Hilo, Hawaii

Honokaa Hospital	Honokaa, Hawaii
Hope Hall Convalescent Hospital (Family Service of Waterbury)	Waterbury, Conn.
Imperial Hospital	Inglewood, Calif.
Industrial Hospitsl	San Juan, Puerto Rico
Industrial Hospital State Insurance Fund	Rio Piedras, Puerto Rico
Inter-Community Hospital	Covina, Calif.
Inyo County Sanitarium	Big Pine, Calif.
Jamatsukuri Neikei Geka Hospital	Yamayu-cho, Japan
The Jewish Hospital of St. Louis	St. Louis, Missouri
Jinnah Postgraduate Medical Center	Karachi, West Pakistan
Kaiser Foundation Hospital	Honolulu, Hawaii
Kauai Veterans Memorial Hospital	Waimea, Hawaii
Kenny Rehabilitation Institute	Minneapolis, Minn.
Knit-Rite, Inc., and W. E. Isle Co., Inc.	Kansas City, Missouri
Kochi Geakuen College of Rehabilitation	Kochi Prefecture, Japan
Kohala Hospital	Kohala, Hawaii
Kaukini Hospital	Honolulu, Hawaii
Kula Sanatorium	Kula, Hawaii
Lake Area Vocational Technical School	Watertown, South Dakota
Lakeland Village	Medical Lake, Washington
Lanai Community Hospital	Lanai City, Hawaii
Lawrence Memorial Hospital	New London, Conn.
Marcus Lawrence Memorial Hospital	Cottonwood, Arizona
Leahi Hospital	Honolulu, Hawaii
Little Company of Mary Hospital	Torrance, Calif.
Long Island Jewish Medical Center	New Hyde Park, New York
Los Angeles Crippled Children's Services	Los Angeles, Calif.
Louisiana State University	Alexandria, Louisiana
Samuel Mahelona Memorial Hospital	Kapaa, Hawaii
Mary's Help Hospital	Daly City, Calif.
Massachusetts General Hospital	Boston, Mass.
Maternity and Infant Care Project	Hilo, Hawaii
Maui Memorial Hospital	Wailuku, Hawaii
Medical Center Clinic Hospital of El Monte	El Monte, Calif.
Medical Center Hospital of Vermont	Burlington, Vermont
Memorial Medical Center of Long Beach	Long Beach, Calif.
Mercy Hospital	Oklahoma City, Oklahoma
Mercy San Juan Hospital	Carmichael, Calif.
Molokai General Hospital	Kaunakakai, Hawaii
Montoe County Community Hospital	Rochester, New York
Mt. Sinai Hospital	Rochester, New York
Mt. Sinai Hospital	Los Angeles, Calif.
Morningside Hospital	Los Angeles, Calif.
Nassau County Medical Center	East Meadow, New York
Nevada Hurses' Association	Las Vegas, Nevada
New England Baptist Hospital	Boston, Mass.
New England Deaconess Hospital	Boston, Mass.
Northeastern University-Boston-Bouve College	Boston, Mass.
Northern Inyo County Hospital	Bishop, Calif.
Northwestern Hospital	Santa Barbara, Calif.
Orthopaedic Hospital	Los Angeles, Calif.
Peninsula Hospital and Medical Center	Burlingame, Calif.

Physical Therapy Services of Waterbury, Conn.	Waterbury, Conn.
Placer Community Hospital	Auburn, Calif.
Pohukaina School, Orthopedic Unit	Honolulu, Hawaii
The Psychiatric Institute	Washington, D. C.
Queen of the Valley Hospital	West Covina, Calif.
Redlands Community Hospital	Redlands, Calif.
Rehabilitation Center, Central Institute of Orthopaedics, Safdarjang Hospital	New Delhi, India
Rehabilitation Institute of Chicago	Chicago, Illinois
Riverside Community Hospital	Riverside, Calif.
Riverside General Hospital	Riverside, Calif.
Rose de Lima Hospital	Henderson, Nevada
Roseville Community Hospital	Roseville, Calif.
St. Anthony Hospital	Oklahoma City, Oklahoma
St. Francis Hospital	Hartford, Conn.
St. Francis Hospital	Tulsa, Oklahoma
St. John's Hospital	Oxnard, Calif.
St. John's Hospital	St. Paul, Minn.
St. John's Hospital	Tulsa, Oklahoma
St. Joseph's Hospital	Syracuse, New York
St. Mary's Hospital	Marquette, Michigan
St. Mary's Hospital	Minneapolis, Minn.
St. Mary's Hospital	Waterbury, Conn.
St. Mary's Junior College	Minneapolis, Minn.
San Bernardino Valley College	Redlands, Calif.
San Juan Veterans Administration Hospital	San Juan, Puerto Rico
San Pedro and Peninsula Hospital	San Pedro, Calif.
Santa Paula Memorial Hospital	Santa Paula, Calif.
Santa Rosa Memorial Hospital	Baltimore, Maryland
School of Practical Nursing	Mitchell, South Dakota
School of Practical Nursing	Pierre, South Sakota
School of Practical Nursing	Sioux Falls, South Dakota
Sheraton House Convatel	Burlington, Vermont
Shriners Hospital	Honolulu, Hawaii
Sioux Falls School of Practical Nursing	Sioux Falls, South Dakota
South Nevada Memorial Hospital	Las Vegas, Nevada
Southern California Permanente Medical Group	Panorama City, Calif.
Spokane Center for Youth Services	Spokane, Washington
Stanford University Medical Center	Stanford, Calif.
State Health Department	Honolulu. Hawaii
State Veterans Hospital	Rocky Hill, Conn.
Straub Clinic, Inc.	Honolulu, Hawaii
Strong Memorial Hospital	Rochester, New York
Sunrise Hospital	Las Vegas, Nevada
Tamatsukuri Seikeigeka Byoin (Orthopaedic Hospital)	Tamayu-cho, Japan
Tampa General Hospital	Tampa, Florida
Tokyo Metropolitan Government Rehabilitation Institute	Tokyo, Japan
U. S. Naval Hospital (Navy Prosthetic Research Laboratory)	Oakland, Calif.
University of Alberta Hospital	Edmonton, Alberta, Canada
University of California, Los Angeles, Center for the Health Sciences	Los Angeles, Calif.

UCLA Child Amputee Prosthetics Project	Los Angeles, Calif.
UCLA Hospital Clinical Laboratories	Los Angeles, Calif.
University of California, Irvine	Irvine, Calif.
University of Colorado Medical Center	Denver, Colorado
University of Connecticut	Storrs, Conn.
University of Florida Hospital	Gainesville, Florida
University of Hawaii	Honolulu, Hawaii
University of Minnesota Children's Rehabilitation Center	Minneapolis, Minn.
University of Minnesota Hospital (Rehabilitation Center)	Minneapolis, Minn.
University of Nevada	Las Vegas, Nevada
University of North Carolina	Chapel Hill, N. C.
University of Oklahoma Medical Center	Oklahoma City, Oklahoma
Veterans Administration Hospital	Los Angeles, Calif.
Veterans Administration Hospital	Minneapolis, Minn.
Veterans Administration Hospital	Northport, New York
Veterans Administration Hospital	San Francisco, Calif.
Veterans Administration Prosthetics Center	New York, N. Y.
Washington Hospital	Fremont, Calif.
Washington University Medical School	St. Louis, Missouri
Waterbury Extended Care Facility	Waterbury, Conn.
G. N. Wilcox Memorial Hospital	Lihue, Hawaii
Workmen's Compensation Fund	Edmonton, Alberta, Canada

APPENDIX I

DEMOGRAPHIC INFORMATION ON RESPONDENTS TO QUESTIONNAIRE "SURVEY OF PARTICIPANTS IN CLINICAL INSTRUCTOR TRAINING PROGRAMS"

1. The types of health care facilities or educational institutions in which respondents were currently employed by percents, were as follows:

1. College or medical school	4.2%
2. Hospital or extended care facility	92.5%
3. No answer	3.3%

2. Size of hospital in which employed:

Over 200 Beds	56.6
100-199 Beds	16.3
Less than 100 Beds	11.9
No answer	15.2

3. Present occupation:

Registered Nurse	146	34.0%
Physical Therapist	61	14.2
Occupational Therapist	40	9.3
Business Office Worker	20	4.7
Prosthetist-Orthotist	20	4.7
Medical Technician	19	4.4
Dietitian	17	4.0
Inhalation Therapist	15	3.5
Radiology Technician	11	2.6
Housekeeping Supervisor	10	2.3
Hospital Maintenance Engineer	5	1.2
Nuclear Medicine Technician	5	1.2
Physician	5	1.2
Laundry Supervisor	4	.9
Social Worker	4	.9
Medical Records Technician	3	.7
Dental Hygienist	3	.7
EEG Technician	2	.5
Purchasing Agent	1	.2
Ward Manager	1	.2
ECG Technician	1	.2
Volunteer Worker	1	.2
Miscellaneous	24	5.6
No answer	7	1.6
	429	100.0

4. Organizational responsibility as indicated by position title:

Supervisor or manager	201	46.9%
Administrator	68	15.9
Educator	73	17.0
Technician	68	15.9
Counselor	7	1.6
Student	3	.7
Miscellaneous	1	.2
No answer	8	1.8

5. Years of experience in present field of work:

1-5	154	36.0%
6-10	113	26.4
11-15	60	13.9
16-20	45	10.5
21-25	31	7.3
26-30	8	1.8
31-40	6	1.3
No answer	12	2.8
Mean 12.5		
Median 8.0		
Mode 5.0		

6. Do you supervise the work of others?

Yes	382	89.0%
No	41	9.6
No answer	6	1.4

7. Educational level

Less than High School	3	.7
High School or Equivalent	32	7.5
Some College	55	12.8
A.A. Degree	199	27.7
Bachelors Degree	152	35.4
Masters Degree	37	8.6
Other	14	3.3
No answer	15	4.0

APPENDIX J

SELECTED COMMENTS FROM SURVEY QUESTIONNAIRES

Please write any comments you care to concerning the Clinical Instructor Training program; what should be done about it if anything, and any other suggestions you may have that will help us decide what to do next. For instance, do you think we should develop similar short participation-type programs in other areas of personnel management for allied health personnel? If so, why? If not, why not?

1. The Clinical Instructor Training program helped me a great deal in trying to teach other nurses and subordinates rehabilitation techniques. The Anderson 4 step method is always used.

Every department's personnel in supervisory positions would benefit from a program such as this especially in in-service training of new workers. (R.N.)

2. This course was most helpful to me in my last position of Inservice Coordinator. I think follow-up training sessions for Trainers would be beneficial for those who are still in training areas--it would be helpful even if we weren't, as the simple basic steps is good background for all who supervise anyone. (R.N.)

3. A short participation-type program should be developed to allow aerospace scientific and engineering personnel (currently unemployed) to be trained to participate in health sciences on both research and clinical levels. The primary emphasis should be in providing communication skills so that they might understand and contribute to the solution of medical problems. (Prosthetic Research Engineer)

4. Due to the shortage of staff, I have been constantly being rotated on different shifts, therefore, unable to carry on such training program. When I took the Instructor's course, I was a Head Nurse and teaching was part of our responsibility but due to reallocation, several of the nurses were down-graded to staff nurse and this is definitely not our responsibility to teach the staff. However, when we attend special courses, we are obligated to teach new techniques-Recently, I attended a month's course on Respiratory therapy, and this area is my responsibility but as far as orienting the new employee is not the staff nurse's responsibility. I do make an outline and always have the "4 Step Instruction" card in front of my notes when I do my teaching. (R.N.)

5. I strongly feel this excellent program should be continued. There is very little training of this type in our occupation. There are many people wanting to participate in Clinical Training program, but no place to get it in our area. (Hosp. Maint. Eng.)

6. I cannot fill out this form as a clinical supervisor, however, I use the technique of job breakdown in teaching allied health supervisors and in-service educators. I also use various modifications of the concept whenever I teach anyone a skill. I have used it with my children, supervisers, household helpers, and students from associate degree to graduate types of allied health workers. (R.P.T.)

7. I feel that presenting this type of program to groups such as the one I had the good fortune being a part of, is the best method for teaching the material. If it benefits this small group, most certainly other areas would benefit provided they can apply the principles. Teaching groups that could never apply it is a waste of time, energy and money! (R.N.)

8. I really enjoyed and learned a lot from your course. I find my biggest problem in the hospital now is "communication." Try as I may to improve them (especially between Nursing Service and my Department-and, I gather, not only my department!) I don't seem to be very successful. Maybe this would be a good subject for a future program. Remember, it is usually the poor patient who ends up the loser! (Occupational Therapist)

9. I am doing Graduate work at Eastern Kentucky University in Criminal Justice. I plan to teach Law Enforcement at the college level. I feel your program was helpful in leading me to a teaching profession. (Business Office)

10. Since I no longer work at this institution, I can really say I did not have time to implement this program in the department. I left the department in January and went back to Staff Nursing. But what small amount of the program I did get to utilize was tremendous and I feel has so much to offer heads of depts. to better inform and utilize their employees to give not only better patient care, but to also enjoy their work. This in turn makes it a constant challenge to not only keep the patient first and foremost in their minds, but give the employees a constant desire to continually improve in their work habits. By doing these things we not only have a happy and well adjusted patient but a good loyal interested employee. (R.N.)

11. I felt it was an extremely beneficial program. Any other program which would help an RN who suddenly is "dumped" into managerial positions would be helpful. RN training is basically doctor and patient oriented-we usually learn to sink or swim the hard way regarding anything beyond patient care--such as: business management, budgeting, cost control, legal problems, new electronic or very specialized equipment, labor problems, etc. (R.N.)

12. The actual participation-(teaching a class member) was most beneficial. The course was somewhat elementary for people who do teaching-though review is always good. Dr. Anderson's enthusiasm and his ability to relate to people is what made the

course successful. He was able to maintain interest. (Dental Hygienist)

13. The validity of this program is going to be dependent on accepting only people who can go back after the training session and teach others. It should also involve administrators and heads of departments to sell them on the idea and get their support. Thank you very much for the outstanding course, I know that I have definitely benefited by it, and hope to teach as many people as possible. (Medical Technologist)

14. If follow-up programs are not established knowledge tends to phase away in the complicated hospital work load in our dept., so --make one large program for supervisors and short follow-up programs for employees. --Yes, similar programs are needed in every area in hospitals, especially where turn-over is high. It develops confidence, personality, and hidden aptitudes, uncovers potential leaders. (Radiology Technologist)

15. Yes, because this course was the most simplified, concise, and direct teaching I have ever received. Not one moment was lost, nothing was too difficult to understand, every session was pertinent and of interest. (Pharmacist)

16. I believe this program would be beneficial to supervisors in any work area-since the clinic shows us our short comings as an instructor-a detailed instruction and training period, produces a better qualified trainee hence less mistakes and less misunderstanding. I hope for the sake of ones who are not acquainted with this program that it will be continued and made available to more institutions. (R.N.)

17. The training session was very good. If we had more time (to return demonstration about 2-3 times) I think I would have felt more comfortable when using the methods learned. The session was very well planned and presented. Since many of our staff do teachings of one kind or another they would all benefit from this type of a program. (Occupational Therapist)

18. Repeat performance and refresher sessions to meet the increasing number of clinical instructors needed. Impact was far from desired as you could not return again, but it still was a very worthwhile experience for me. (Inhalation Therapist)

19. I think the program as is-is excellent-should be continued in institutions-involving all services. I am in favor of the development of similar programs--WHY--Because they are needed and wanted--supervision-administration-etc. (R.P.T.)

20. Having sat through so many poorly taught courses in the Medical Field, I think this Clinical Instructor program would help anyone in a responsible position, to communicate better with allied workers whether they be medical personnel, clerical, etc. I can remember the times "If the student hasn't

learned, the teacher hasn't taught!" (R.N.)

21. Most people who are responsible for allied health training programs, including myself, have no formal educational training in education. We have "evolved" into our present positions due to our expertise in some special related area or for other such reasons. Therefore, I feel that programs such as yours should be continued and expanded. This would certainly improve the quality of training now being offered. (R.P.T.)

22. I think that the program should be continued especially with instructors like Dr. Anderson. It has helped me tremendously with a better harmonious work situation with my secretary during the period I was working for Vocational Rehabilitation. So much time and confusion were eliminated when I exercise what I've acquired from this training. I think that this type of program will be very beneficial to participants who exercise what they learned from the program. (Vocational Rehabilitation Counselor)

23. I found the program an excellent change of pace from my present position. I found it to be a great opportunity to learn many facets in the para-medical profession and to be able to meet different people. It was especially rewarding to teach, I mean really teach, the four step method since I found that 99% of people attending the classes that I taught really learned. (Hospital Administration)

24. I was just getting to know my fellow students by the time the current program was over. I would have welcomed more time and further group discussions and technique demonstrations. Are there any films on this at present?

Cannot say enough about your fine abilities, Miles, the time will always be cherished in our memories. Incidentally and as a result of attending class with one of the other employees, and when a training supervisors vacancy came up I was able to easily select this person as the top candidate as a direct result of his impressive class participation. Michael Polo was the man. Best wishes and hope to see you return here. We now have our formal classroom areas and offices open and are developing full time curriculum for our Building Services Department. (nee Housekeeping Dept.) (Mgr. Hosp. Bldg.Services)

25. I enjoyed the program, found it quite useful in teaching. I plan to use the techniques more-now that I am going into a different type of teaching program. It is possible that a training program such as this might be sponsored by a nursing organization such as the Georgia State League of Nursing--then the participants would come from schools, hospitals, throughout the State. Perhaps the Regional Medical Program might be interested in this. (R.N.)

26. The continuation of the Clinical Instructor Training for the allied health professions should be considered as priority No. 1. It can be most beneficial to large hospitals or institutions, including all other health care facilities. Example: a) hospital - college joint educational program.

I feel that this program was well planned and presented. It was very educational and benefited by all. Those who have had the privilege of attending the Clinical Instructor Training program were very fortunate. It has helped very much especially in the supervisory department. The instructor taught and the learner learned. (R.P.T.)

27. Well done presentation very good because of the participation. Very interested to learn about the varied departmental problems in teaching and how they were carried out. Short participation programs in other areas would be one way to enable various allied health personnel to understand each others problems and mechanics of their particular specialty. (Hospital Maintenance Engineer)

28. I found the two days stimulating and very enlightening. I feel it was time well spent and I'm grateful to my hospital for sending me to this program. (R.N.)

29. I do feel and really believe that the Clinical Instructor Training Program was great, real great, and I will give full recommendation to keep similar short participation type programs of this class, like I said before it was real "Great." (Hospital Laundry Supervisor)

30. I sincerely believe that you are doing a great job in running this Clinical Instructor Training program. However, at the 2 hospitals I have worked I found very little opportunity to put the principles we've learned into use, simply because of the fact that they don't have any formal training programs for dietary employees at all, like they have in other fields of allied health. I'm hoping though that we will have one in the near future. (Dietitian)

31. I have always felt that there is a marked lack in management training for allied health personnel in supervisory and department head positions. Perhaps a short concentrated course on management techniques and principles would be of benefit. I am a graduate of the management school of hard knocks and I did not find this education very pleasant and I am not sure that I learned my lessons well.

I did gain a great deal from your course and find it was valuable in both my roles as Technical Director of my own department and as a clinical instructor for Northeastern. (Inhalation Therapist)

32. In explanation of my evaluation on page 3: Your course was really a refresher for us O.T.s who have all had to study a chapter in our text very similar to your presentation. Since the principles you taught were supposedly what we should have put into practice daily in your work it merely served to remind us to consciously break down whatever we were teaching to pts. In discussing it with other O.T.s who took the course, we all are in agreement that it was extremely well done. It was put so even a "dum-dum" couldn't help but get the information, and the practice sessions were <u>great</u> for making each participant really learn the stuff. I confess I have been to many programs where I made notes, put them aside with the intent of studying them further-never looked at them again ever. Couldn't do it in your course! Length of course was perfect. Never had a chance to be bored. Feel I know these principles much better than I did. Keep teaching this. (O.T.R.)

33. You have done a very fine project-which-if everyone extends it to their student body as we continue to do, has done a great deal for the professions in health fields. Just keep on doing it if you can find the money and strength, especially at the Associate Degree Level which is rapidly developing in America. (R.P.T.)

34. The Clinical Instructor Training Program was very helpful and useful. It would be a very good idea to have a refresher course and also one on implementing the program. Other areas of personnel management would benefit from this program because of the problems they have instructing, giving directions, etc. (R.N.)

35. I gained a great deal of assurance from your program, and was able to maintain instruction in patient care in my area. Have not tried to use much further except maybe in educating my 2 daughters to home tasks. I find myself using the method also in organizing groups in my outside social life. It is a program very worthy of maintaining if only to give a confidence to the few supposed leaders like me. (R.N.)

36. I enjoyed the program very much and have used the technique especially in preparing teaching sessions in my own institution. However, I feel the course was a bit brief to use as an everyday working tool. The total participation aspect was particularly outstanding as a part of the course as was the manner of presentation. (Medical Technologist)

37. I would like to have a Clinical Instructor Training program for the nurses in the Supervisory capacity. They need to learn how to teach their own staff-not only teach but recognize what to teach-basically-"ward management" is needed here. Do you suppose a seminar could be set up for them. 3 whole days, a week maximum-on the job training? I would be interested to know your comments on this. I have tried to answer the questions, as much as I understand them. Please write when time permits.

I am still doing inservice education for the staff so I have benefited a great deal from having attended your program. (R.N.)

38. Although I do not feel the training program has improved relations between cooperating hospitals and colleges in carrying on joint programs to any great extent, I do feel it was a tremendous help to me as an individual and has improved my effectiveness in teaching workshops to therapists in the area. Possibly a program aimed toward helping supervisory personnel would be helpful. For instance, a program to prepare a therapist or other professional to supervise personnel either as a senior therapist or as head of a clinic. I feel the clinical instructor training course should be continued and should be offered to new personnel at institutions periodically. Also review sessions should be continued. (R.P.T.)

39. I really enjoyed the program which you presented in Hilo. To be truthful, I haven't had any opportunity to teach the course, since I'm only a staff nurse. I have used the knowledge gained among the practical nurses and aides, that work under me. It has helped me to realize that you can't relate, unless you use the "Four Steps" of instruction. I hope I have been of some help, I feel you haven't gained much from my questionnaire. (R.N.)

40. There is no question but what the course was of value to our personnel. However, the do-it-yourself approach in implementing the techniques and development of training manuals presented a problem in that this work was superimposed on the additional responsibilities of our personnel and, unfortunately, ranked down the list of priorities. The attention to day-to-day operating matters take precedence. I feel that outside assistance in this area, development of the training manuals and implementation would have been beneficial. It would have enabled us to take better advantage of the techniques and principles covered in the course. Also, I think we would find a program of seeking better ways to do the job beneficial. A follow up of this type may be worthy of consideration. I should point out that Dr. Anderson was very willing, and in fact did look over and evaluate some of the material we developed after this course was presented. (Chief Exec. Of.)

41. I think that some of our "errors" that we made during our teaching could have been pointed out to us so as to aid us with future teaching of classes. I know that positive re-inforcement is the thing to do, however, when you take a class to learn how to be a more effective instructor that if some of the bad points are not brought out and you made aware of them, then we will continue to do these things and still be an ineffective instructor. In other words, I believe some constructive criticism should be incorporated into your program. I do think that this program would be beneficial to allied health personnel. I think a program along this line would make management more aware of their responsibilities to train personnel under them. All too often this responsibility is left to other department members to carry out and it usually ends up a hit and miss situation leaving the new and old employee very frustrated. (R.N.)

42. Do not wish to be pessimistic but when I attended--although good information was given--was spread over too many days--wasted time. Good information-but not as much as I expected, too elementary if you are working with educated persons with some teaching administrative background. You taught a technique. Being too sketchy on the principles. Would suggest continuing the general area of clinical training but expand to give additional principles in management and supervison and offer more practice time and require more practice in "breaking down" areas. Perhaps in a group session, and as my students tell me--don't just read handout material--but supplement it or just give it to us and let us read it on our own then discuss and debate ideas presented. Dr. Anderson, you have excellent ideas and organizational ability, but in this course I felt you did not challenge us to our capacity. You could have given more--we could have done more. Now please understand that I teach in an academic setting predominantly and not often in the clinical so I may certainly not be seeing the magnitude of possibilities for your program. I did learn and have (gratefully) used the principles you presented. (R.P.T.)

43. I think a refresher course would be perfect at this time. (R.N.)

44. Programs in other areas of personnel management are of utmost importance due to the increase of problems involving the area of money related to care of patients. How this affects the cure/ treatment; other factors of management related to patient care. (R.P.T.)

45. Extend technique to apply to teaching more theoretical information in clinical setting. Too much stress on technique. Learning "how to" applies to a very limited area of our knowledge. Develop program on how to teach in lecture-type situations-there are too many poor lecturers! (M.D.)

46. It really was not too pertinent to my work. This type of instruction would work best to more basic training or learning of fundamentals, shop work, etc., I believe. (M.D.)

47. Although I felt that the intent of the program was justified and fulfilled, I found it less than useful in my own area of instruction. This is due to the fact that my area is primarily theory rather than skill instruction. The program as is is very thorough and yet I feel it should be shorten by eliminating a bit of the repetition. If in conjunction with this some help in the area of theory instructional techniques, the preparation of examinations, location of reference material etc. the value of the program would improve. (M.D.)

48. I did not feel that the course I had was adjusted to the educational level of those participating. It was structured for a much lower level of educational background. It was a waste of time and money. The one thing I learned was to never present a program without considering orienting it to the level of those participating. (M.D.)

49. I felt the initial presentation was excellent and of course, my learning was intensified with "demonstrating" the learned principles. However; I didn't think two sessions were necessary for demonstrations as after 2 or 3 everyone knew what to expect, what not to do etc. Perhaps to shorten the time, two groups could have been formed and had two demonstrations going on simultaneously. By the third session, I felt things were getting too repetitive. (R.N.)

50. In many ways I felt that the program was too basic. I've been training students for eight years now and felt relatively familiar with the techniques. Our problems are more related to: 1) what to do when all else fails, 2) how to formulate a program so that the student can learn on his own (we haven't time to teach them everything) and 3) how to teach the intangibles--getting along with the patient, dealing with attitudes expressed by patient. (O.T.R.)

51. Perhaps you should broaden the depth of your study. I thought that only the superficial knowledge was being presented and that there was a lack in what was presented. It was a little too easy. (R.P.T.)

52. There should be a careful check on those instructors who have completed the program. I had the misfortune to attend a session that was poor. If a method of testing the Clinical Instructor could be implemented, it would avoid this error in total response. (R.N.)

APPENDIX K

C.I.T. PROGRAMS SPONSORED BY OKLAHOMA
REGIONAL MEDICAL PROGRAM
EVALUATION REPORT
JANUARY 1971 - MARCH 1971
EVALUATION OF CLINICAL INSTRUCTOR COURSE SERIES

BACKGROUND

During the period from January through March a series of three clinical instructor courses was conducted. The first two courses in the series were held on January 12-13 and February 24-25 at the O.U. Medical Center in Oklahoma City. The third course in the series was presented on March 23-24 at St. Francis Hospital, Tulsa. The two-day, twelve-hour interdisciplinary courses were presented by Dr. Miles H. Anderson, Director of Clinical Instructor Training Program at the University of California, Los Angeles. Local sponsorship was provided by the Oklahoma Regional Medical Program which provided staff support and administrative assistance. Collaborative support of the program series was also provided by the O.U. Medical Center, Oklahoma City, and St. Francis Hospital, Tulsa. Financial support was obtained from two sources, a special federal grant available to Dr. Anderson and a $15 registration fee for each student. The federal support is provided by a direct grant from the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare on the basis that programs that improve health care also improve vocational rehabilitation.

Total attendance for the series was thirty-six. Due to the personalized nature of the instruction, enrollment for each course was limited to a maximum of 12 students. Representation from Oklahoma City and Tulsa was excellent. A substantial number of students represented a significant portion of the major hospitals in both cities. In the Oklahoma City area, student representation included, O.U. Medical Center-17, Mercy Hospital-2, St. Anthony Hospital-2, Baptist Hospital-1, Children's Memorial Hospital-1, and Rose Jr. College-1. The Tulsa area representation included St. John's Hospital-3, St. Francis Hospital-3, Oklahoma Osteopathic Hospital-2, Hillcrest Medical Center-3, and County Health Department-1. Occupational backgrounds included residents, nurses, radiological technologist, inhalation therapists, dieticians, dental hygienists, medical technicians, pharmacists, cytotechnologist and administrators. Present occupational positions of students included professors, associate professors, education coordinators, research, health occupations training coordinators, supervisors, instructors, and clinical instructors.

The courses of study provided instruction in teaching techniques for clinical instructors in the allied health occupations and included practice in developing step-by-step job training and course outlines. The four main steps of instruction stressed by Dr. Anderson were preparation, presentation, application and testing. Typical student reaction to the course material

and presentations by Dr. Anderson was highly favorable and most enthusiastic. In general the students expressed the view that the course was very informative and stimulating, and the presentation of course material was considered to be excellent and relevant to student professional needs.

GOALS AND OBJECTIVES

The immediate goals of the course were to:

1. Develop an understanding and appreciation for the potential application of Clinical Instructor training.
2. Develop an acceptance and endorsement of the Clinical Instructor training program by key medical staff and supervisory personnel.
3. Assist medical educators and supervisors in applying more effective teaching techniques.
4. Make key medical personnel more effective in their daily performance and functional job breakouts.

The immediate objectives were to:

1. Teach each member of the class how to teach others to perform specific job tasks by use of the four tools of instruction - telling, showing, illustrating, and questioning.
2. Make each member of the class qualified to serve as a trainer capable of giving the Clinical Instructor training course himself.

The long-range objectives of the Clinical Instructor training course were to:

1. Improve on-the-job training for workers in allied health professions and occupations.
2. Provide better medical service and reduced costs through improved training programs, resulting in better trained workers making fewer errors, and more effective use of time and materials.
3. Improve the quality of self-care and home care of patients by improving the teaching skill effectiveness of nurses and therapists in communicating with and training patients and their families to perform home care tasks.

METHODOLOGY

The curriculum was developed by Dr. Miles H. Anderson, who also served as faculty for the course. The basic reference material, a "Clinical Instructor Training Program Trainer's Manual," was also developed by Dr. Anderson.

The general concept of the course was based upon the training techniques first applied in defense plants during World War I, which have been continually refined and proven useful in a variety of settings. The purpose was to provide intensive, practical, skill oriented training for specific tasks carried out by allied health personnel in hospitals and extended care facilities. The academic schedule involved a period of two days with three four-hour class sessions. On the first day Dr. Anderson presented the first four hours of instruction, providing the students with an understanding of this training technique. The students then had time to prepare for the second day, during which the last two four-hour periods of instruction were conducted. The last day was primarily devoted to student demonstrations and discussion. During this phase each student selected a job from his occupation, made a breakdown of it, and taught it to another member of the group, applying the techniques in the same way he would in a practical, on-the-job situation.

Upon completion of the working session and demonstration of ability to give the course themselves, students were granted a Clinical Instructors Trainer Certificate. In addition, they received a trainers manual and all necessary instructional materials. When local trainers (graduates of the class) put on their own class, they are sent certificates for their trainees from the UCLA training center, and graduates of locally conducted courses become officially registered and qualified clinical instructors.

FINDINGS

Of the 36 students attending the course, 29 completed the student evaluation form attached as enclosure 1. In summary, student observations and responses were as follows:

1. Without exception the students expressed the view that the course was very informative and stimulating. The method of presentation of course material was considered excellent to very good, and relevant to their professional needs. Group participation was excellent and stimulating. The academic atmosphere was especially conducive to learning. Further, they expressed the view that the course was very functional and that the techniques presented could be applied regardless of the quality of one's academic background, B.S. degree, associate degree, or nonprofessional. The student class participation aspect of the course appeared to be most helpful. One student expressed the view that he would have liked to have had more constructive criticism during student teaching sessions from the instructor and class members.

2. All of the students felt that course attendance was time well spent. Without reservation 93% of the students felt that the course of instruction was useful to them in their present position. Some 97% were of the opinion that participation in this educational program would make them more effective in their daily performance. None expressed the view that the course was not useful.

3. As mentioned before, student professional backgrounds included obstetrics, dentistry, physical therapy, inhalation therapy, medical technology, dietetics, cytotechnology, radiology and other health related professions.

4. An average of the collective work time students spent on various daily job responsibilities indicated that they devoted 36% of their time to instruction and 41% of their time to administrative duties. Patient care duties required approximately 18% of the collective job work time, and research and student counseling utilized the remaining 4% and 1% respectively. Approximately 66% of the students felt that this program effectively assisted them in the development of functional job breakdowns and only 31% thought it was too early for them to make such a determination. Only 3% did not believe that functional job breakdowns were related to their position responsibilities.

5. Some 76% of the students expressed the belief that this program would help them in developing course outlines and applying more effective teaching techniques. For the remainder of the students, it was either too early to know or not applicable to their position responsibilities. However, all of the students expressed the view that they planned to use this technique in an inservice or on-the-job training program for health professions or occupations within their respective disciplines. Their primary reasons for wanting to use this technique were to improve training of new employees, help students to teach others, achieve better organization, become more effective in teaching skills, and observe student progress more effectively. Without qualification, some 83% of the students felt that this technique would be useful in teaching patients and their families in home care techniques, especially for dental health, physical therapy, dietetics, specimen taking, use of respiratory equipment, and all types of home care health instruction. Primary student reasoning for endorsing this technique was that it would conserve time, effort, and finances, and improve the efficiency of health care. One student made the observation that "it should be a fast and effective means of teaching them self-care on an out-patient basis."

6. Students were unanimous in expressing the view that this program could be practically applied to skill-oriented training programs of other medical facilities and centers within the state. They suggested that this technique could be usefully employed in many skill-oriented allied health programs. They also suggested that the technique could be used by clinical instructors of students so that they could plan better learning experiences for the students. Specifically they expressed the view that this technique could be usefully employed in the education programs of rural or remote hospitals, nursing homes, county and state health departments, Bureau of Indian Affairs and any institution that has an established training program in the health occupations or an active inservice education program.

7. With reference to their own disciplines, none of the students could think of any reason why this instructional method could not be applied effectively to allied health professions or occupations. They recommended use of the technique in any profession related to teaching and made specific references to nursing service, dentistry, vocational teachers, orderlies, nursing aides, technicians, intensive care units, public health, occupational therapy, radiology, etc. One of the reasons for adopting this teaching technique for the above subjects was that it appears to be an invaluable time saving device.

8. Student motivation achieved by Dr. Anderson was most exceptional in that practically all students planned to apply this teaching technique in one or more situations. Interest in serving as faculty on an occasional basis to promote this program in other areas of the state was expressed by 69% of the class. Only 21% of the student body said they would not be interested in serving on such a faculty.

9. Student enthusiasm for the course was practically unanimous. Only one student expressed an unfavorable comment and that was he felt the course was too long and more time was spent on the course than was necessary. He felt that one day would do the job. This student, however, also expressed the opinion that attendance at this program was time well spent and that this method of instruction would be useful in making him more effective. Practically all the students expressed a desire to share this new knowledge and experience with others. Pertinent observations were as follows: "I think this can be a most helpful technique in my profession." "I feel that the interaction with the other health professions and occupations was very beneficial." "This approach to clinical instruction is excellent." One student, from an experience standpoint, expressed the view that this course was needed and would be most useful for nursing personnel and occupational therapists working in convalescent homes. A typical reaction from another student was that the course gave him a new insight into teaching and he plans to put these new ideas into practice.

10. Evidence of the favorable impact of the Clinical Instructor training upon the training of health related occupations is readily apparent. Martha Ward, R.N., a student in the January course, has subsequently concluded three workshops for 19 supervisory nurse personnel, utilizing the teaching and instructor techniques gained from Dr. Miles Anderson's course of instruction. Student reaction to presentation of the course by a local trainer has been equally enthusiastic and responsive. Reference is made to enclosure (2) which contains extracts of student statements in response to the evaluation questionnaire.

CONCLUSIONS:

Analysis of the student response to the evaluation form indicates that all the immediate course goals and objectives were achieved. Expressions of strong desire by all the students to adopt part or all of this educational technique to their daily job responsibilities indicates the possibility of major changes in their behavioral patterns. It also appears that there was a general acceptance that use of this technique could conserve time, effort, and finances. If this proves out, it could have a favorable effect upon cost reduction of medical care.

In part, some of the long-range objectives of the Instructor Training Course have been achieved. There is evidence that on-the-job training for workers in some allied health professions and occupations have been improved through use of the training technique.

RECOMMENDATIONS:

Recommend that follow-up evaluation procedures be developed to determine changes in behavioral patterns and the long-range effect of this program upon medical skills. Important factors that should be observed would be the impact upon inservice and on-the-job training courses resulting in improvements in efficiency and effectiveness of patient care. Future evaluations should attempt to respond to such questions as: Have improvements in effectiveness resulted in fewer errors in administration, patient care procedures or service support operations? Is there any evidence of more efficient use of time or materials, resulting in overhead cost reductions that could be passed on to the consumer? In addition, follow-up evaluation procedures should also consider what improvements, if any, have occurred in the area of home care as a direct result of improved teaching techniques. Finally, what impact, if any, has this teaching technique had upon improving the overall quality of patient care by allied health professionals?

Enclosures (2)

ENCLOSURE (1)

COMPOSITE
EVALUATION FORM
CLINICAL INSTRUCTION COURSES
OF
JANUARY 12-13; FEBRUARY 24-25; MARCH 23-24
1971

1. In concise terms, what would be your overall evaluation of the course content and method of presentation?_____

2. Do you feel that your attendance in the program was time well spent?
YES 29 NO_____

3. Have you found this method of instruction useful to you in your present position? YES 27 NO_____ THINK IT WILL 1 HAVE NEVER TRIED IT 1

4. Do you think that participation in this educational program has made you more effective in your daily performance? YES 28 NO_____ No response 1

5. Please describe your present position_____

6. Please indicate the per cent of time you generally devote to class instruction 36%; patient care 18%; administration 41%; research 4%; other (please explain) 1% (student counseling)

7. To what extent has participation in this program effectively assisted you in the development of functional job breakdowns?

Most effective	9
Effective	10
Somewhat effective	
Ineffective	
Too early to know	9
Not applicable to position responsibilities	1

LEGEND: 29 out of 36 students completed the evaluation form. The numbers in the blocks represent the total number of students who marked each block. In question #6, the percentages indicate the composite of the members of the class in their regular daily job performance.

8. Has participation in this program assisted you in developing course outlines and in applying more effective teaching techniques?

Most effective	11
Effective	10
Somewhat effective	1
Ineffective	
Too early to know	5
Not applicable to position responsibilities	2

9. Within your discipline do you plan to use this technique in an on-the-job training program for health professions or occupations? Please explain.

YES = 100%

10. In your area of interest do you feel these techniques could be useful in teaching patients and/or their families? YES 24 NO 1 No response 1 PERHAPS 3 . Please explain.

11. Do you feel that this program could be practically applied to skill-oriented training programs of other medical facilities and centers within the State? YES 29 NO ____. If so, where would you suggest?

12. What allied health professions or occupations related to your discipline do you feel could effectively apply this instructional method?

13. If ORMP provided the administrative support, would you be interested and available to serve as faculty, on an occasional basis, to promote this program in other areas of the State? YES 20 NO 6 No response 2

To early to know 1

14. Other comments

ENCLOSURE (2)

STUDENT COMMENTS FROM CLINICAL INSTRUCTION COURSE
LOCALLY SPONSORED AND PRESENTED
February 16-17; March 22-23; 29, 30
1971

(1) In concise terms, what would be your overall evaluation of the course content and method of presentation?

It is a very much needed course and the method was compact & well presented.
Very well presented.
Both were presented in a learning atmosphere with a small group of people. The contents of the course were precise, but well prepared. Presentation was informal and questions were welcomed.

Very informative. We were made to feel at ease and enjoy the program. The program never dragged and stimulated our interest at all times.
I felt it to be most interesting, and quite an eye-opener. Over the years I forgot about someone just starting in this profession and I believe I expect too much at times. I feel the more on the staff who get to doing the same way it will be less confusing to new employees.

It helped me to realize how little people understand what we try to teach them at times. I think the presentation was very well done.
Very meaningful because it was well organized, specific and utilized the principles being taught.
Meaningful, well presented, and definitely applicable for all Inservice Personnel and prof. nursing personnel.

(5) Please describe your present position.

Director OB-Gyn
Medical Nursing Consultant
Responsible for nursing care given to patients, assisting in teaching personnel, counselling personnel, and directing Head Nurses

Head Nurse; Intensive Care Unit
Director of Pediatric Nursing

Instructor, Operating Room technicians
Instructor, Inservice Education, VA - Okla. City
Associate Chief, Nursing Service for Education

(9) Within your discipline do you plan to use this technique in an on-the-job training program for health professions or occupations? Please explain.

Yes. I hope to assist the Head Nurses in developing this type teaching method for all personnel.
Aid with inservice for staff & teaching with patients.
I plan to hold workshops for my Head Nurses so their on-the-job training may be more effective.

Yes. It made me realize the importance of small groups, and group participation. I have always used some of these steps, but never all of them together.
Yes. I feel this technique should be used when new procedures or new equipment is placed in nursing areas.

Yes.
Yes. In orientation, skill training and staff development. It will be useful for all levels of personnel.
Hopefully, eventually - yes.

STUDENT COMMENTS FROM CLINICAL INSTRUCTION COURSE
LOCALLY SPONSORED AND PRESENTED
February 16-17; March 22-23; 29, 30
1971

(10) In your area of interest do you feel these techniques could be useful in teaching patients and/or their families?

It is a positive approach and allows the student to ask questions.
Basic method would enhance learning by patient and family
I work with patients of children and we do much teaching as diabetics, tube feedings, meningocele care, and cast care. This technique will make our teaching more effective and remind us to be more precise in our planning.

Frequently we are sure we have explained something sufficiently until we take it one step farther and ask for a return demonstration.
In teaching or working with parents to become more familiar with working with this child, often they go home whether the child will need to be tube fed-or is a diabetic-this technique can be used.

These techniques could be used in our own homes, esp. with children.
The diabetic, orthopedic, dialysis, colostomy, etc - any patient and/or family who will be continuing treatment after discharge.
It is a very basic and helpful method that lends itself to a one to one situation.

(11) Do you feel that this program could be practically applied to skill-oriented training programs of other med. facilities & centers w/in the State? Where?

In small hospitals anywhere in the state, especially where a supervisor might do most of the In-Service Teaching and few training facilities are available.
Job Corp School, Guthrie, Okla.; Schools for mentally retarded; Nurse Aide Courses
No response - 1

I think it could be used in just about anyplace where a specific skill is taught. It seems that the time spent in getting the skill across is shortened in the long run.
In the allied health profession since these are ones I am more familiar with.

Okla. State Tech. for one.
Job Corps Centers, schools of nursing, it can be applied to any learning situation.
No response - 1

(12) What allied health professions or occupations related to your discipline do you feel could effectively apply this instructional method?

Public Health
LPN, NA
Nursing Students; Ward Clerks; Scrub Technicians; Oxygen Therapists; Physical Therapists; Orthopedic students or orderlies.

Same as #11 (I think it could be used in just about any place where a specific skill is taught.)
Nurses Aide, clerks, scrub tech., LPN, RN, almost any ---

I believe this could benefit any occupation.
X-Ray, lab OT, PT, or any area that requires skill training.
All nursing personnel could apply. The task determines the category or level of personnel who would use the method.

STUDENT COMMENTS FROM CLINICAL INSTRUCTION COURSE
LOCALLY SPONSORED AND PRESENTED
February 16-17; March 22-23; 29, 30
1971

(14) Other comments:

No response - 1

Very worthwhile technique.

This course made me realize my teaching methods were not as effective as I thought. I thought one of the most important steps I learned was to have the teacher and learner in same situation under same conditions and to be explicit. Also, to teach one skill at a time and correct mistakes promptly.

No response - 2

No response - 1

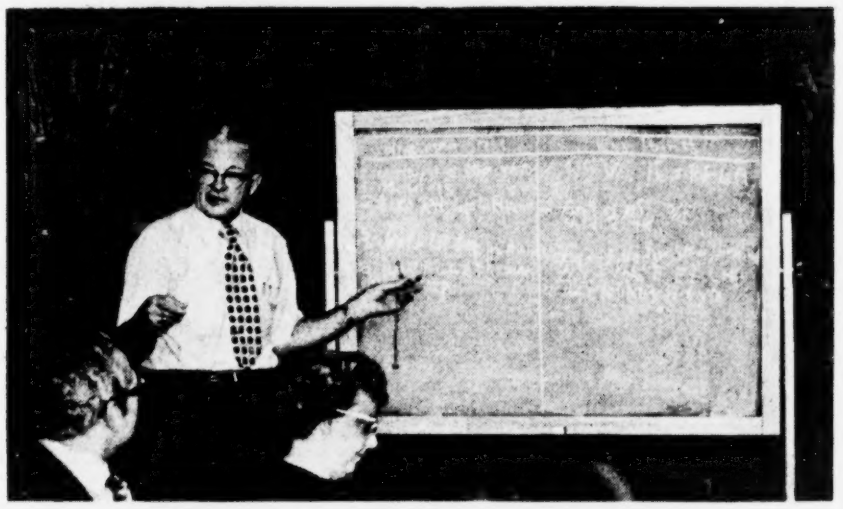
Thank you for the opportunity.

I feel most fortunate that I was afforded the opportunity to participate in the clinical instruction course. It has caused me to become much more aware of the analytical approach to learning.

3 CLINICAL INSTRUCTOR TRAINING PROGRAMS HELD

A "Clinical Instructor Training Program" has been held in Oklahoma City in January and February and in Tulsa in March. The interdisciplinary short course offers instruction in teaching techniques for clinical instructors in the allied health occupations. It was sponsored by Oklahoma Regional Medical Program.

Miles H. Anderson, Ed. D., Director of Clinical Instructor Training Program at the University of California in Los Angeles, conducted the twelve hour courses. The program included practice in developing step-by-step job training and course outlines, and in applying teaching techniques.



Dr. Miles H. Anderson leads discussion at program held in March.

Students practice teaching process at Clinical Instructor Program.

The main approach is to instruct potential trainers, who could then teach the same program to other groups.

The approach employed by Dr. Anderson is one which is based on training techniques first applied in defense plants in World War I, which have since been revised continually and proven useful in a variety of settings.

The four main steps in instruction, stressed by Dr. Anderson, were preparation, presentation, application, and testing.

ORMP NOW OFFERS MONTHLY CALENDAR OF EVENTS

Oklahoma Regional Medical Program now offers a monthly calendar indicating continuing education opportunities and meetings of interest to health professionals in the state of Oklahoma.

The calendar has been issued for the past two months and sent to Regional Advisory Group Members, ORMP Project Coordinators, State Health Associations, Hospital Administrators, Nursing Home Administrators, ORMP Staff, Health Planning Agencies, OU Medical School Deans, and anyone else requesting a copy.

Any items to be included on the calendar should be submitted by the 25th of the preceding month. This cut-off date will insure timely receipt of future issues. All submissions or queries should be made to Jack White or Carole Byrd at 820 N. E. 15th Street, Oklahoma City, Oklahoma 73104, (405) 232-9561.

APPENDIX L

QUESTIONNAIRE ON CLINICAL INSTRUCTOR COURSE

Children's Hospital of Los Angeles

TO:

FROM: Clinical Instructor Training Staff

SUBJECT: QUESTIONNAIRE ON CLINICAL INSTRUCTOR COURSE

It has been the objective of this hospital to send those people who are in some way involved in teaching to this training course. In order to effectively evaluate the course, we would appreciate you answering these questions.

1. In what way have you utilized the training?

2. Do you fully understand how to make Job Breakdowns?

3. Have you written any job breakdowns for your section?

4. How may we improve the presentation of our course?

5. In what ways have your supervisors assisted you in this training?

6. Are there any aspects of the course that you did not like?

Please return to either Andre Streaty - Clinical Lab, or Crissie Pettit - Personnel by January 4th, 1970. Thank you.

APPENDIX L

Children's Hospital, Los Angeles

QUESTIONNAIRE RESULTS

Number sent out: 92

Number returned: 41

1.) In what way have you utilized the training?

a) Training new employees - 5
b) Orientation - 7
c) To write job descriptions - 2
d) To teach students - 11
e) To instruct parents - 6
f) For more teaching awareness - 1
g) For increased demonstration technique - 1
h) Not involved in teaching - 2
i) No application found - 2
j) Teaching new techniques - 4

2.) Do you fully understand how to make job breakdowns?

yes - 36 no - 5

3.) Have you written job breakdowns for your section?

yes - 19 no - 19
Breakdowns used with mental process - 3

4.) How may we improve the presentation of our course?

OK as is - 25

a) Send those that have the authority to train others
b) Listing jobs - have trainees select a job from this list and teach it
c) More time - 5
d) Continue with enthusiasm
e) Break class in half - play skits
f) Use less detailed presentation
g) Better seats and a warm classroom
h) No application found - 2
i) Shorten time - 2
j) Better classroom

5.) In what ways have your supervisors assisted you in this training?

Not at all - 8 Full support - 16
1) Placed program into actual practice - 7
2) Encouragement - 7
3) Verbal support - 3

6.) Aspects about the courses that were not liked.

None - 38

1) More time needed
2) Answering questionnaire
3) Too complicated demonstrations

CLINICAL INSTRUCTOR TRAINING A HAPPENING IN LEARNING

To care for sick children is a special privilege. To constantly improve that care is our responsibility.

In this highly specialized age of scientific medical advances, many of us fall prey to the misconception that improvement of patient care depends on sophisticated equipment and miracle drugs. Not so. Improvement of patient care begins with the human touch.

Well trained hospital personnel can make a greater contribution to patient care than haphazardly instructed employees. Recognizing this, Childrens Hospital in 1968 authorized LuAnn Darling, our Training Consultant, to invite Dr. Miles H. Anderson of the University of California at Los Angeles, Division of Vocational Education, to introduce and teach his Clinical Instructor Training Program. The six-hour course is not limited to any particular hospital field. It rather focuses on the method of teaching how to give simple, easy to follow instructions to anyone in any kind of teaching situation.

Each day that we are on the job, all of us are involved in teaching: Giving parents directions, training new employees, instructing students, showing patients or parents how to do a certain procedure — all are a form of teaching and in one way or another relate to the excellence of patient care.

Under Dr. Anderson's guidance, a nucleus of 12 employees learned the proven four-step method of effective teaching: Preparation. Presentation. Application. Test. This method is not a new teaching technique. It was successfully used in World War I and World War II by industry and improved efficiency of production considerably. Dr. Anderson revived the course and made it applicable for hospitals. He received a three year grant from the Department of Health, Education and Welfare, Social and Rehabilitation Service and the program is now well known in health institutions throughout the country and abroad.

The course has been taught here continuously since 1968. Joan Kish, Instructor in Radiology, was one of the original teachers. As new instructors were recruited from subsequent classes, Joan became less active in the program but she is still a staunch supporter of it.

The following are now involved in teaching CIT sessions: Crissie Pettit, Dove Pinkney, Andre Streaty, and Cindy Westcott. Clinton Ball and Dan Hart are standbys. Andre and Cindy have also become coordinators for the Program. More than 150 employees have graduated and many, many more are reaping benefits from it.

Enthusiastic comments about CIT indicate that a revolution in many areas of teaching has taken place at Childrens Hospital. "I've become aware that I have been giving instructions in too technical terms," "I know now that I taught too much at one time," "I realize I did not follow through after I gave instructions," "I gave scanty information," "I didn't motivate my students," are but a few examples of the comments made.

At a recent meeting with Childrens Hospital coordinators and teachers, Dr. Anderson articulated his thoughts about What is Learning? "Learning is a happening. Learning is when a person changes his own behavior, gets rid of certain attitudes and acquires skills, knowledge and new attitudes. Teaching is helping people to change their own behavior."

The motto of the Clinical Instructor Training course is "If the learner hasn't learned, the instructor hasn't taught." What a challenge to the teacher, what a comfort to the learner.

Frances Weindler, R.N., Poison Information Center, instructs CIT classmates in the operation of HEAR (Hospital Emergency Administrative Radio). Dove Pinkney, instructor, listens and learns, as do ten of her students (not pictured).